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Creative Interventions in Mental Health:
A Critical Analysis of the Mindfulness
Agenda in Sussex

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**A study submitted in fulfilment of the
requirements for the degree of Doctor of
Philosophy in Sociology
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DECLARATION

I hereby declare that this study has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature:.....

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ABBREVIATIONS

ATC:	Assessment Treatment Centre
BMJ:	British Medical Journal
BPS:	Biopsychosocial
CBT:	Cognitive Behavioural Therapy
CAM:	Complementary and Alternative Medicine
CG:	Clinical Governance
DSM:	Diagnostic and Statistical Manual of Mental Disorders
EBM:	Evidence-based Medicine
EBG:	Evidence-based Guidelines
ECBT:	Emotion-focused Cognitive Behavioral Therapy
ICD-1:	International Classification of Diseases
IM:	Integrative Medicine
LEAP:	Lived Experience Advisory Panel
M4V:	Mindfulness for Voices
MBI:	Mindfulness-based Intervention
MBCT:	Mindfulness-based Cognitive Therapy
MBSH:	Mindfulness-based Self Help
MBSR:	Mindfulness-based Stress Reduction
MHF:	Mental Health Foundation
MHRN:	Mental Health Research Network
MUS:	Medically Unexplained Symptoms
NICE:	National Institute for Health and Care Excellence
NHS:	National Health Service
OMC:	Oxford Mindfulness Centre
PM:	Participatory Medicine
QALY:	Quality-adjusted Life Year
RCT:	Randomised Controlled Trial
SPFT:	Sussex Partnership NHS Foundation Trust
SMI:	Serious Mental Illness
STS:	Science and Technology Studies
SU:	Service User
VBM:	Values-based Medicine
OCD:	Obsessive Compulsive Disorder

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ABSTRACT

Mindfulness-based Cognitive Therapy (MBCT) is a manualised psychosocial, group-based 8 week course specifically designed for people with a history of depression. This study responds to the huge growth in the credibility of MBCT as a therapeutic option in the NHS as well as a rise in the popularity and awareness of mindfulness-based interventions (MBIs). This study is based on semi-structured interviews (N=38) with stakeholders in the field of MBIs in Sussex, and an online survey of Sussex NHS Foundation Trust (SPFT) staff (N=203), as part of a wider collaborative ethnography embedded within the Trust. It contributes to existing literature on the efficacy of MBIs by exploring existing provision and follow-up support, reviewing the perceived benefits and costs of embedding MBCT into the health services. This study has a particular focus on participants of a recent SPFT Randomised Controlled Trial (RCT) '*Mindfulness for Voices*' that investigated the efficacy of this therapy for people who hear distressing voices.

This study brings together both the empirical and theoretical with its focus on mindfulness as a therapeutic technique that epitomises links between the mind, the body and society. This study draws on sociological work on embodiment and emotion in order to understand the experience of innovation as well as of MBIs – starting from the observation that many of those leading this area of research and implementation are also practising mindfulness. Furthermore, this study maps the theoretical shift from a narrow medical model of mental illness to one that characterises emotional health within a holistic and integrated paradigm, and which is influencing and shaping current practice.

Key findings from this study are that MBIs, and MBCT in particular, can be beneficial to a diverse range of stakeholders within Sussex, including patient groups that were previously excluded from 'talking cures' such as those with a diagnosis of psychosis. Factors that influence the acceptability, visibility and utilisation of an innovation such as MBCT include the role of opinion leaders and champions in garnering support, as well as the degree to which expectations about the future of this intervention are managed. Drawing on sociologies of knowledge and innovation in the health services, the case is used to show the use of experiential knowledge alongside evidence in bringing about innovation. Clinicians also work to develop accounts of the 'values' at stake in MBIs; drawing on both evidence and experiential knowledge. The implementation of MBIs into the mainstream health service helps to illuminate some of these practices through

being used to address conditions such as chronic pain and severe anxiety disorders which were hitherto seen as untreatable and characterised as 'complex needs', or medically unexplained symptoms (MUS) and which can be stigmatising.

CHAPTER 1. MINDFULNESS, OF THE MOMENT

- **1. Overview**

‘Mindfulness’, the meditation technique based upon Buddhist philosophy to train the mind to be in the present moment, has become a commonplace and everyday term as a result of a wealth of scientific studies, media coverage, and the rise in popularity of pluralistic approaches within medicine (Saks 2003). It is difficult to define mindfulness completely, but important to seek as much clarity as possible on the ways in which it has been used by particular individuals positioned within a particular tradition or agenda. Mindfulness training is both a complement and alternative to mainstream medical care, and has been termed a form of ‘participatory medicine’ in which individuals are encouraged – often within peer groups - to use their own resources to understand and address their condition (Black 2010). Despite its popularity, mindfulness has also been subject to misunderstanding and debate about its definition, origins and content in manualised course form, and its implementation for different user groups (Petrik & Cronin 2014).

In the past 40 years, interest in mindfulness and mindfulness-based interventions (MBIs) for therapeutic uses have increased significantly. A recently published report analysing data from 47 clinical trials including 3,000 individuals which controlled for placebo effects, suggested that practicing mindfulness produced measurable improvements in symptoms of anxiety and depression of up to 20% when compared to those practicing another activity, whilst also helping to address stress and improve quality of life¹ (Goyal et al 2014). Despite the significant rise in the use of ‘talking cures’ in NHS mental health care in the UK (Clarke 2011), the role of emotions and emotional wellbeing in their delivery, as well as user experiences, has been relatively neglected within both medical sociology and the sociology of emotion.

Mindfulness-based cognitive therapy (MBCT) is a packaged intervention within Sussex Partnership NHS Foundation Trust (SPFT) and the predominant form of MBI implemented in the UK. SPFT is the mental health trust for the whole of Sussex and is sub-divided in to East Sussex, West Sussex, and Brighton & Hove, and an organisation which asserts a particular set of values and the importance of staff wellbeing. This

¹ Negative thoughts and feelings remain markers for vulnerability to relapse and recurrence of mental illnesses such as depression, and psychological interventions can reduce this reactivity, and with it the risk of relapse (Segal et al 2006).

study explored how MBCT has been embedded in this particular mental health service, which is working with it as a therapeutic technique provided through a free NHS service '*Health in Mind*' in East Sussex (Health in Mind 2015). The research highlights how mindfulness/MBCT became relevant for policy-makers, practitioners, service users and clinical research trial participants². The study explores how expectations about the future of this intervention were managed and mediated by these groups. It also addresses questions arising from the fact that many health professionals within the Trust are *themselves* practising mindfulness, including whether prior interest in, and personal mindfulness practice amongst, health service professionals impacts upon organisational culture, referral patterns, and funding decisions.

This study addresses the impact of MBCT as a therapeutic intervention in the form of emotional management, the embodied experiences of course participants (as well as myself as a researcher), and ways in which such emotions become important in organisational responses to MBIs. In this study emotions are understood not only as the link between mind and body, embedded as they are in a biological substrate, but also fundamentally social as they shape and are shaped by all forms of interaction, hence linking mind, body and society. They are multidimensional and manifest themselves in bodily reactions, and have both cognitive and unconscious dimensions (Bendelow 1993). Examining these dimensions of emotion is essential for a healthy mental state (Ryff & Singer 1998), as well as enabling sociological understandings of the relationship between the mind, body and society, and institutional, interpersonal, and subjective experiences within contemporary healthcare. Emotions have also been shown to enable cooperation and relational strengths, with potential effects on both individual and organisational levels (Vacharkulksemsuk et al 2011). In this study I draw on the work of Rivera & Paez (2007) to explore 'emotional climates' within the particular organisation of SPFT.

This introductory chapter grounds this study within discussions of the rapid growth of MBIs in the UK health service, and their particular position within SPFT.

- **2. Mindfulness-based interventions in Sussex**

SPFT has a reputation for exploring creative therapeutic approaches in mental health through research. I define creative as the practice of borrowing from different traditions,

² These categories not being mutually exclusive.

looking beyond biomedicine, and the seeking of new ways of involving and engaging patients.

Since 2012 the Trust secured funding for research into the efficacy of MBIs for older people, adolescents, and the treatment of obsessive compulsive disorder (OCD). The most recent research is MBIs for people experiencing psychosis and distressing voices, following suggestions that an adapted MBCT could help people suffering from schizophrenia and experiencing distressing voices (Chadwick et al 2000). A randomised controlled trial (RCT) recently completed by SPFT; '*Mindfulness-based therapy groups for distressing voices (M4V): A pragmatic randomised controlled trial (RCT)*' aimed to evaluate the effectiveness of an adapted form of MBCT which sought creative means to help individuals learn different means of living with distressing voices. This study was able to explore the experiences of participants of this trial through qualitative research, and to situate the trial within the particular setting of the Trust (including policies and practices for service user involvement and evaluation). This study also investigates engagement with mindfulness and M4V by both physicians and patients across the Trust.

My collaborative studentship was conducted through the Research & Development department of SPFT based in Brighton & Hove who provide services across the whole county of Sussex. Research relationships were established with members of SPFT as well as the wider voluntary and community sector. The use of 'creative' in the study title signifies both the innovative approach taken by SPFT as well as the potential of MBIs to offer new approaches alongside biomedical therapies in mental health settings and more broadly.

- **3. UK context**

This field of research has broad significance because of the surge in popularity in MBIs and growing demand for mental health services to treat psychological distress. One in four individuals experience a mental health problem annually (MIND 2014). The economic impact of poor mental health problems has been estimated to be £100 billion in the UK, with the cost of work-related stress in the UK has been put at more than £30 billion annually, and hidden costs on top of this possibly much higher (MHF 2013). The importance of these hidden costs is vital in terms of the impact of structural and funding changes in the NHS on levels of service provision (including MBIs), as well as on the lives of those working within these services. Changes in the core structure of the NHS

following the 2010 Health and Social Care Bill predominantly took effect from 2013. NHS services have been opened up to competition from providers, with local authorities taking on more responsibility for budgets for public health but with limited growth in resources (NHS 2014).

- **4. Theoretical background**

A significant body of literature has evolved over the last 20 years analysing the integration of mindfulness practices with conventional healthcare from both conceptual and empirical perspectives, and attempting to identify the key mechanisms of change (Teasdale et al 2000; Kuyken et al 2008; Chiesa & Serretti 2011). A formative review by Baer et al (2008) revealed a five-factor structure of mindfulness of observation, acting with awareness, and non-judging and non-reactivity, and found that many of these factors predicted particular psychological outcomes. Key elements of mindfulness such as awareness and non-judgemental acceptance of momentary experience, are seen as counters to anxiety, anger, and rumination, all of which can involve the avoidance or over-engagement with emotions and thoughts that can be distressing (Hayes & Feldman 2004; Kabat-Zinn 2013).

A central agenda of focus in this study was the integration of mindfulness principles within cognitive behavioural therapy (CBT), a psychological approach to address mental health problems by examining patterns of thinking, emotional reactions and behaviour (Sheldon 2011). According to the psychologist Geschwind, MBCT, a theory-driven intervention conceived of with the aim of reducing relapse in recurrent depression, is linked to an increase in the experience of positive emotions and present-centred attention which then improves the ability to manage negative emotions as well as an increase in responsiveness to (as well as appreciation of) daily-life activities (2011; see also Hanley & Garland 2014). The integration of traditional mindfulness training with CBT (Cayoun 2011) became formalised through the publication of *Mindfulness-Based Cognitive Therapy: a new approach for preventing relapse in depression* by Mark Williams's team in Oxford (Segal et al 2002). Results since this study have further evidenced the relationship between mindfulness and positive mental health (Coffey et al 2010), and on an organisational scale mindfulness has also been shown to reduce stress, foster compassion, and improve quality of care in the health service (Ludwig & Kabat-Zinn 2008).

Mindfulness was framed for centuries to be a part of Buddhism and other spiritual

traditions, thought the application of MBIs in Western biomedical and mental healthcare contexts is more recent, and fundamentally began in the 1970s through the work of Kabat-Zinn (1982, 2013). Much empirical and theoretical work since has illustrated the impact of mindfulness on psychological health (Keng et al 2011), and the number of publications addressing the efficacy of MBIs for varied medical and psychological conditions has risen steeply in the previous decade.

The application of MBIs within Western biomedicine has needed to adhere to the requirements of evidence-based medicine (EBM); 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett et al 1996: 71). Subscribing to the 'rationality' of EBM allowed the incorporation of MBIs into the health service to be a legitimate pursuit, a means of further evidence generation, source of RCT funding, and for MBCT to be included in the National Institute for Health and Care Excellence (NICE) guidelines. The endorsement of MBCT by NICE is considered in this study in terms of the emphasis on EBM and evidence-based clinical guidelines (EBG) within psychiatry and mental health services (Haynes & Haines 1998; Oakley 2000; Kaptchuk 2001).

In terms of the interpretation of evidence generated through EBM and EBG, key academics exploring this field have included Singleton (in Mol 1998: 86-104) and Armstrong on the use of anti-depressants (1995, 1996, 2009) - who suggested that it may be equally important how evidence is defined as how it is interpreted and utilised - and Greenhalgh et al (2005). Regarding the varied influences on the interpretation and utilisation of evidence, bodies of literature to be addressed in this study include; the role of opinion leaders (e.g. Flodgren et al 2011) and champions (e.g. Hendy & Barlow 2012), as well as expectations in mobilising both resources and collective responses to innovation (e.g. Brown & Michael 2003; Moreira & Palladino 2005). The field of Science and Technology Studies (STS) is also a valuable source of studies of expectations and innovation (e.g. Doganova et al 2014).

The rise in popularity of MBIs can be understood within the global provision and use of traditional, complementary and alternative medicine (CAM) over the last 40 years (Barcan 2011; Gale & McHale 2015). This has taken place in a context of market reforms and emphasis on consumer choice and consumption of services (Lucivero & Prainsack 2015) and changes in structure of the NHS (Cant & Sharma 1999), though take-up and most importantly access to these therapies has been varied (Ernst 2000). Of particular interest is the position occupied by MBCT within 'talking cures' and

prescribing of CBT through the Improving Access to Psychological Therapies (IAPT) programme (Summerfield & Veale 2008; Clark 2011).

In the sociology of medicine and health, attempts to move beyond the Cartesian legacy has brought a renewed interest in sociology putting ‘minds back into bodies, bodies back into society and society back into the body’ (Williams & Bendelow 1998: 3), which has informed work on CAM as well as mental health and wellbeing. Understandings of the mind-body interface, as well as the limits of biomedicine, have become increasingly subtle, including physiological changes associated with conventional stress, and emerging research on neuroplasticity and the effects of consciousness (and *unconsciousness*) on mind/body regulation and wellbeing (ibid; Lawton et al 2000; Dacher 2014).

- **5. Research questions and study contribution**

- 1. What are mindfulness-based interventions (MBIs) and how are they being engaged with and experienced, in particular through mindfulness-based cognitive therapy (MBCT)?*
- 2. Who is promoting and working with MBCT as a form of innovation in Sussex Partnership NHS Foundation Trust (SPFT), and how does this innovation acquire currency?*
- 3. What are the implications for future mental health policy and practice, both within Sussex and nationally?*

Although giant strides have been made in mindfulness research, the need remains to interrogate the nature of MBIs and engagement with them on both the experiential and institutional level. This area of enquiry follows May in questioning the ‘conditions in which knowledge is mediated into decision-making contexts, and how [it] is understood and used when it gets there’ (2006: 513). While MBCT is now available in some NHS Trusts, Crane and Kuyken argue that its implementation has been rarely strategic, coherent or appropriately resourced, and that since NICE first included MBCT in its recommendations, only a tiny minority of mental health Trusts have implemented this guidance in systematic way³ (2013).

³ Organisations with a strategic plan to implement MBIs have tended to be those in which MBIs were widely available; the training and supervision of therapists was supported; referrals decisions were appropriate; and classes given sufficient resources (Crane & Kuyken 2013).

This study contributes to existing MBI literature by exploring MBI provision and follow-up support within SPFT as well as in the wider community and exploring facilitators that have enabled and impede its implementation. It also builds on previous research examining MBIs for psychosis (Chadwick 2000, 2008).

The study is also a case-study of SPFT as an institution and how it deals with innovation, adding value to this area of study by incorporating theories of emotion, implementation science, and sociological concerns together with the organisation and delivery of mental health services, and work with evidence. Centrally it is also a study of the lived experience of those attempting mindfulness practice for themselves. It is this potential to practice the therapeutic techniques by oneself that distinguishes MBIs as innovative⁴. The following chapters take both a theoretical and empirical approach, with specific relevance to current policy and practice within mental health services in Sussex and more broadly, examining problems faced in terms of a reduction in resources to meet an ever growing clinical need.

- **6. Study structure**

Because the literature considered includes widely debated concepts and areas of enquiry this study has two separate literature review chapters. The first literature review focuses on the conceptual frameworks and theories needed to approach the question '*What is mindfulness?*', and the second review elaborates on how these theories and concepts shaped particular forms of knowledge and practice in therapeutic institutions and practices.

Chapter 2 Beyond Cartesian Dualism: conceiving emotions as linking mind/body/society sets up the conceptual framework employed in this study, beginning with sociological and philosophical challenges to the dominant 'Western' paradigm of biomedicine. Critiques of the mind/body divide and the processes of medicalization were a key influence on a responding growth in integration of biological and social models of health and illness along with conceptions of mental health and wellbeing. Starting to address the question '*What are mindfulness-based interventions?*' requires attending to emotion and embodiment. This chapter further

⁴ This study can thus be used to further examine the broader basis for scientific knowledge claims and questions such as; '*How we know what we know?*', '*How do we study or attempt to understand the subjective and embodied experience of others?*', and '*How do others interpret and articulate this knowledge in themselves as it develops?*' (Barnes 2013).

outlines the contribution made by sociology of emotions to theories of embodiment, and posits emotion as the key concept linking the mind, body and society.

Chapter 3 Knowledge and practice in mental health today combines both academic and policy-orientated material across social science, mental health and public health studies using the thematic content of the theoretical debates in Chapter 2. It considers evolving debates around EBM, NICE and RCTs, and the contribution of literature driven by an alternative set of values to day-to-day practice in psychiatric and therapeutic work based on a narrow curative focus. The history of medical pluralism, rise of CAM, and MBIs are considered in the context of these bodies of work.

Chapter 4 Methodological discussion outlines the main aims of the study, then details the research methods used, the approach taken to data analysis, and the evolving research process. It discusses the theoretical, practical and ethical issues that arose and how these were addressed and managed. Reflective considerations are made of my position as a researcher and own embodied experiences of mindfulness, and the implications these factors had for my study.

Chapters five, six and seven then draw on the data collected in response to previous theoretical discussions.

Chapter 5 'Lived Experience'; emotion and embodiment in Mindfulness-based interventions explores the nature of this therapeutic approach through the personal experiences of MBI participants, and how this therapy differs from cognitive approaches in terms of acknowledging the unconscious. This builds on my literature review to develop an empirical account of how MBCT is 'done' on the ground. It examines how emotions were invoked in the empirical data about the embodied experience of MBIs, the individualising configuration of the body and sense of self, and considers the significance of socio-structural factors in shaping these experiences. MBIs are characterised here as a form of emotional management as Hochschild proposed (1983, 1990, 2012). The subject of much academic debate, this chapter highlights emotions as deeply personal and difficult to categorise, focusing on how this often ephemeral concept relates to the policy and practice this study explores.

Chapter 6 Innovation; expanding the reach of Mindfulness-based Interventions begins by interrogating the term 'innovation', then presents data on the practicalities of MBIs as a particular form of innovation in Sussex, considering how this data throws

light on previous literature. This literature helps to answer the question of how MBIs are being engaged with and who is promoting and working with them elaborating on the organisational context and the strategies pursued by key stakeholders. The argument is made that formal evidence is necessary but not sufficient in spreading awareness, and that an embodied evidence strategy is pursued by opinion leaders within the Trust. This strategy has been discussed by other authors writing about individual clinicians and their experiments with new therapies. In this case it appears at an organisational level, fitting into practices within the Trust that seek to connect with lived experience. Attitudes to MBIs as a treatment option for psychosis and awareness of the M4V RCT are set in the context of the role of evidence-based guidelines (EBG). Some of the barriers to applying research evidence to health care are identified, and emotions are presented as intrinsic to involvement with innovation.

Chapter 7 Imagined future of Mindfulness-based interventions presents the future of MBIs as discussed by study participants. Exploring their hopes and fears the chapter addresses the different valuation practices at work, and debates about 'alternative values' that help shape the environment in which mindfulness can find a place. MBIs are framed as an expression of a particular set of values looking beyond short-term outcomes but also acknowledging the current economic environment within the NHS.

Chapter 8 Final reflections considers the content of the study, and draws together the analysis of the previous chapters and key emerging themes. It also suggests directions for future research.

CHAPTER 2. BEYOND CARTESIAN DUALISM: CONCEIVING OF EMOTIONS AS MIND/BODY/SOCIETY

- **1. Introduction**

This chapter first explores sociological concerns relating to the dominant Western paradigms of dualism and biomedicine. These concerns include the processes of medicalization; by which conditions are defined and treated in medical terms, and governmentality; a term used by Foucault (1973) to describe the power of the state over the bodies of its citizens and how this power can become internalised. The norms and values that have shaped these theories are inseparable from the Cartesian legacy in Western psychiatry. Descartes conceived of the mind and the body as separate entities, and this dualism has had implications for forms of treatment within modern psychiatry. Psychiatry as shaped by biomedicine has formed particular understandings of mental illness and mental health, with the condition of psychosis in particular reflecting broader debates over definition, diagnosis, and treatment.

Sociologies of the body have been key in responding to Cartesian theoretical traditions, asserting the integration of biological and social models of health and illness. Theories of embodiment have also challenged the assumption of the body and mind as separate and independent forces by suggesting that the body helps to constitute the mind in shaping emotional responses, in particular those to stress. Recent sociology of emotion therefore helps show how the mind and body are interrelated, and provides a way of conceiving of this relationship.

Defining emotion is notoriously problematic and definitions have often varied across disciplines (Baer 2006). This chapter attempts to develop a working concept of emotion arising from the empirical data, in theoretical frameworks influenced by the seminal work of Hochschild (1983, 1990, 2012). Emotions are defined in this study emerging from a biological substrate, manifesting themselves in bodily reactions with both cognitive and unconscious dimensions, but as fundamentally social in the sense that they are shaped and manipulated to conform to socio-cultural norms and demands (Hochschild 1983; Bendelow 2009). In this way, emotions are positioned as the central thread between the diverse and yet linked bodies of literature addressed in this study, bridging the division between nature and culture, and highlighting links between the mind, body, emotions and wider society (Hochschild 1983; Williams & Bendelow 1998; Milton 2005). As stressed by Hochschild (*ibid*), emotions can also be subject to training

and management, skills that parallel the focus of MBI practice. The developing field of emotional organisations and emotional management skills of employees and managers is also relevant to this study in the context of Sussex Partnership NHS Foundation Trust (SPFT).

- **2. Biomedical model and challenges**

- **2.1 Biomedicine and medicalization**

The term biomedicine indicates the set of practices that brings biological and clinical knowledge, norms, tools, and procedures to bear upon each other (Rajan & Leonelli 2013: 464).

The biomedical model concept is often used by sociologists as a means of describing the dominant Western paradigm of scientific medicine. Biomedicine has its basis in a pathological view of the body, which in the nineteenth century broke away from earlier considerations towards the idea of *specific* diseases with *specific* causes (Bury 2013). Often credited to Descartes distinction between the *res cogitans* and the *res extensa*, the former referring to the soul or mind and the latter the material stuff of the body. A key assumption of this model has been that the mind and body can be treated separately (ibid). This so-called Cartesian dualism positioned the mind over the body, with the former constructed as both civilised and rational (Turner 1992; Howson 2013). Cartesian dualism typically reduced individuals to so-called 'body machines', revealing the socially controlling propensities of biomedicine (Foucault 1973). The Foucauldian approach, which remains influential within medical sociology and the analysis of the human body, institutions and government, argued that the body, disease and contemporary medical discourse were inseparable (Turner 1992; Bury 2013). Alongside Foucault, another formative radical engagement with biomedicine was Jewson's 1976 paper '*The sick man*'. Bedside medical care for the sick was argued by Jewson to have disappeared from medical discourse during the period 1770-1870 (1976). According to Jewson's argument, the 'sick-man' had previously had more control over his own treatment, but as control over knowledge was centralised into the hands of the senior members of the biomedical establishment, this opportunity was replaced by a consensus of the opinions of a community of medical investigators within laboratories (ibid).

By the mid-nineteenth century, different conceptions of disease such as those based on observation and 'bedside medicine' (Jewson 1976), had given way to

epistemologies that located disease in specific organs, and privileged biological processes and structures over the cultural, social and biographical (Nettleton 2010 in Cockerham ed. 2010: 47-69). Jewson's paper remains influential within medical history (Nicolson 2009), and sociologists have aimed to extend the temporal sequence of bedside to hospital, to laboratory medicine, including Armstrong who argued that a further 'medical cosmology' of 'surveillance medicine' had emerged early in the twentieth century (1995).

Another central sociological framework for understanding medical practice, knowledge and the medical encounter has been medicalization, 'defined as a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders' (Gabe 2013, cited in Gabe & Monaghan ed. 2013: 49). As part of this process, diseases are shown through identifiable symptoms and signs understood as departures from the 'normal' (Nettleton 2010 in Cockerham ed. 2010: 47-69). Although not used explicitly as a term, medicalization was originally used by critics of the growing influence of psychiatry in the 1960s to describe the application of medical knowledge to behaviours not self-evidently medical or biological (ibid). The term then entered 1970s sociological enquiry as linked with the concept of social control through the work of Szasz (1960), Zola (1972), Conrad (1979), among others, and has since been applied to a variety of putative problems both physical and psychological that have come to be defined as medical (Gabe & Monaghan 2013).

If sociology understands biomedicine has working through a split between mind and body, it has to explain how psychiatry makes a space for itself as medicine for the mind. Though this is a complex process, psychiatry fits within biomedicine with its attention to an 'illness' or 'disorder' that is seen as requiring medical intervention, to move someone from an 'abnormal' to 'normal' state.

○ 2.2 Psychiatry as science and medical specialism

Through its growth as a medical specialism, psychiatry is part of the story of both biomedicine and medicalization, but takes as its focus the mind *in* the body. Miller and Rose developed a critique of what Rose termed the 'psy' disciplines (2008), the self-given task of which has been to classify mental distress into recognisable categories, to describe clinical manifestations and epidemiology, and offer treatment options (Comte & Guze 1995). Contrary to the majority of medical conditions that are defined by their aetiology (cause), or pathology (damage to the body), mental illnesses have tended to

be only defined by their (supposed) predominant symptoms (Burton 2008). However, Rose argued that problems with mental or emotional health are increasingly attributed to malfunctions in the physical brain (2003). Concurrently, key aspects of individuality are likely to be defined in bodily terms, alongside efforts to improve or cure the self through acting on the body, activities which Rose termed 'somatic individuality' (ibid). The ways in which psychiatry has grappled with the body has acted as both a cause - and as part of the solution – to the effective treatment of multiple mental health conditions and the incorporation of emotions into these treatments.

Through the empirical lens set out above, the late 20th Century was characterised by an increase in expert knowledge and discourses around emotional expression, with the 'psy' disciplines attempting to measure emotional responses and improve the way that people deal with and express them (Williams & Bendelow 1998). These disciplines were seen as enlightening through attempts to 'cure', in a march of progress narrative that needs to be acknowledged alongside the coerciveness highlighted by Foucault (Burnham 2000). Psychiatry can also be said to have changed in responses to both internal and external critiques. As a result of this scrutiny, the biomedical development of 'mental illness', far from being neutral, the basic concepts and methods of psychiatry have been argued to constitute a paradigm whose methods of theory and observation are 'uniquely inappropriate to its subject matter' (Ingleby 2004: 42). A central focus of these critiques of psychiatry has been the role of diagnosis. Under the biomedical system the ability to diagnose became paramount, based on test results and judgments about 'deviations from the normal'. Revisions have been made to diagnostic categories and classification systems such as the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the International Classification of Diseases (ICD-1) used in the UK, and 'with each revision comes new diagnostic groups' (Pilgrim & Rogers 2010: 266), and boundaries for category of depression have continued to expand (Williams 2003). Advocates of the DSM draw explicit links between DSM and the legitimacy of the 'medical model', but these developments remain highly controversial (Bracken et al 2012).

The history of diagnosis can be read in relation to a single condition, with psychosis a prime example. It was in the late 1800s that Kraepelin's classification of mental disorders first defined 'dementia praecox' (schizophrenia) (Burton 2008), with psychosis used as a 'generic term for a mental state involving a 'split'...a loss of contact with reality and manifested by delusions or hallucinations' (ibid: 71), and categorised in the UK as a serious mental illness (SMI). Psychotic symptoms include

auditory hallucinations (that can be conceived of as intrusions into awareness), and delusional beliefs (interpretations of these intrusions), both of which can cause distress (Morrison 2001).

The linguistic origins of the schizoid 'split' reflected how the treatment of schizophrenia at the time fitted the Cartesian divide between the mind and the body (Boyle 1990; Dunn et al 1999). Psychosis as a remaining diagnostic boundary is a key example of the emergence of diagnosis as part of psychiatry. Bentall argues that the core assumptions of the Kraepelinian paradigm have been embraced unconsciously, making it difficult for both researchers and clinicians to think outside of these structures (2006).

○ 2.3 Further challenges to biomedical epistemologies

This chapter has set out how sociology of medicine has engaged in critical discussion about the history and role of psychiatry, and has helped to highlight that the development of the medical model has not always been accepted, even by doctors who are sympathetic to scientific medicine (Ingleby 2004). Indeed the 1960s and 1970s saw a number of critiques emerge from *within* medicine (Bury in Gabe & Monaghan 2013). Among others, Thomas Szasz, and R.D. Laing came out strongly against the application of the medical model to mental illness. The 1970s also saw strong reactions by key epidemiologists to what they saw as the 'over-reliance on curative medicine, and too great an influence on the role of the biomedical establishment' (ibid: 112).

The work of Foucault was pivotal in conceiving of the growth in the power of biomedicine and medical conceptions of disease as neither inevitable nor irreversible⁵ (1973: 3). In no small part due to the influence of this analysis, disease (or lack of well-being) is acknowledged by many within the sociology of health and illness as located within the body of a 'person', which exists within a broader context (Nettleton 2010, in Cockerham ed. 2010: 47-69). From this perspective health status and patterns of morbidity and mortality are neither random nor biologically determined, but vary according to social class, gender and race, age (ibid). There has subsequently been far more analysis of the role of socio-economic inequalities in both mental and physical health (Pilgrim & Rogers 2010).

It has become increasingly recognised that equal concern is needed for individual's psychological, physical, and social functioning and with patterns of informal care, as for

⁵ Resistance to biomedical conceptions of disease are explored further in Section 6.

diagnosis or medical treatments (Lovell & Susser 2014). These developments can be usefully examined through the critical and post-psychiatry movements, which challenged key tenets of traditional psychiatry from within, providing much needed scepticism about the diagnostic nosologies of biomedical psychiatry, the coercive role of 'big pharma', and preventive detention (Bracken & Thomas 2001). Critiques of the pharmaceutical paradigm in mental health will be discussed in more detail in chapter 3.

As well as having coercive elements, the project of psychiatry has also had humanising aspects and attempted to incorporate a broader understanding of mental distress. The term 'psychosocial' has become widely used to illustrate a paradigm in which structural elements of society and the impact of culture on mental health may be integrated, whilst also exploring aetiology (Williams & Ramon 2005, in Ramon & Williams 2005: 13-25). A key member of the post-psychiatry movement, psychiatrist Duncan Double has argued for a 'biopsychosocial' (BPS) model. Double strongly opposed what he saw as a neo-Kraepelinian expression of biomedicine, and argued that psychiatry should complement as well as act to temper biomedicine with psychological and social understandings, recognise uncertainties existing within clinical practice, and refocus on the patient as a person (2002). Double et al also drew important links between the increase in psychiatric treatments (such as 'talking therapies' and psychotropic drugs), the raising expectations of solutions to mental health difficulties, and the broadening of traditional boundaries of psychiatric disorders and controversy surrounding the DSM-V, in which 'everyday problems regarded as the province of other social spheres become 'medicalised' by psychiatry' (2002: 900).

The BPS model has gained much popularity amongst physicians since the 1980s as its multi-causal and inclusive definitions of mental disorder allowed for a variety of perspectives to be accounted for in diagnosis and treatment *beyond* bio-reductionist accounts (Alonso 2004; Pilgrim 2002, italics mine). Difficulties have been identified however in applying the BPS model to medical care where it may appear in competition with the traditional biomedical concept of health. It has also been suggested that practical concerns could have driven the pluralism that now exists within mental health services, rather than the BPS model specifically⁶ (Alonso 2004; Smith et al 2013).

6 The BPS model has also be criticised for not fully addressing mind/body dualism, with clinicians addressing biomedical symptoms and the psychologist or psychiatrist the psychosocial elements (Smith et al 2013).

Developing critiques over diagnostic criteria set out in Section 2.2, rather than viewing mental health and illness as occupying opposite ends of one continuum, Keyes proposed that mental health be seen as a state on a continuum of both mental *illness* and mental *health* (2010). Symptoms of mental health have also been argued to consist of individuals' subjective well-being, in turn reflecting perceptions of experiences through affective states and social and psychological functions (ibid). An increasing amount of evidence has added weight to the argument that wellbeing is more than simply the absence of pathology (Ryff & Singer 2008), and is in fact good for both individuals and for society (Frey & Stutzer 2010). Wellbeing levels have been associated with positive outcomes such as good health and life expectancy, effective learning, good relationships, pro-social behaviour, productivity and creativity (see Dolan et al 2008; Huppert & So 2011). This work helped to further challenge the biomedical model of psychiatry (still very dominant in theory and practice), and assert more holistic paradigm of MH.

Following from this holistic focus and as part of the engagement with *the social*, mental health has also been argued to be a relational rather than individual concern in terms of the impact of external variables on an individual (Anthony 1993; Stansfeld & Candy 2006). Literature critiquing modern conceptions of madness, distress and misery as understood through specialist bodies of knowledge within psychiatry, has also shown the damage caused through the designation of distress as illness (Craib 1994; Rapley et al 2011), a process which obscures 'the features of modern society that make sanity a precarious state for many people', and contrary to current medicalised understandings, reveals some forms of mental illness to be a natural reaction to unnatural circumstances (Rapley et al 2011: 257). A so-called 'normalising approach' has also thus been put forward, with the 'view that so-called mental illnesses are actually meaningful responses to difficult situations, which a sympathetic application of common sense can easily make intelligible (Ingleby 2004: 13; Dillon 2011, cited in Rapley et al 2011). Ingleby has also argued that 'there is surely something irrational about such exclusive concentration on treatment of the symptoms, when in fact these supposed illnesses seem to be generated as an inevitable by-product of our way of life' (2004: 7). Further tensions provoked by the biomedical model of mental health are explored in Chapter 3.

The contribution of sociologies of the body in the paradigm shift away from the biomedical model of psychiatry and emergence of a more holistic paradigm of mental health will now be explored (Bracken & Thomas 2005).

• 3. Sociology of the body

The body has typically been marginalised within biomedicine as extrinsic and biologically-based, and consistently presented as ‘threatening to overcome the pureness of thought’, responding to the passions rather than the reasoned will of the mind (Fox & Ward 2008: 2). Difficulties within sociology in pinpointing the body as object of inquiry also lie in the fact that the body is rarely the object of experience, with Western culture not in the habit of cultivating this experience (Csordas 1999).

In asking where the body is in sociology today (Turner 1984; Williams 2006), others have been raised, including why the biological body matters, or the biological be included in analysis, and what the raising of this question might entail. Indeed, according to Williams, in many ways medical sociology has *always* been about bodies⁷ (2006):

‘Sick bodies; healthy bodies; medicalised bodies; disabled bodies; reproductive bodies; dying bodies; dead bodies; and so on. The historical development of medical sociology, however, has meant that it is only relatively recently, thanks in no small part to the upsurge of interest in body matters both inside and outside the academy, that the body has become an explicit topic of discussion and debate’ (Williams 2006: 7).

Turner’s *Body and Society* was a key early text examining the body as material, and socially or politically constructed [1984] (2008). An explicit rethinking of the body was indeed due to the work of the French existential-phenomenologist Merleau-Ponty, who in the 1940s and 1950s challenged the primacy often given to the thinking and rational subject, through a re-conceiving of perception or ‘corporeal schema’, studying the richness of experience through sensory perception (Crossley 1995, cited in Williams & Bendelow 1998). Phenomenology – the study of subjective experience - offered the opportunity to transcend the traditional Cartesian dualisms which positioned the body as a passive pre-cultural object (Moran 2013). Merleau-Ponty aimed to reflect upon the ‘unreflected’, to ‘bring back to the centre of our attention and awareness that *pre-objective*, primordial relationship we have to our bodies and the world, one which objective thought loses sight of’ (Csordas 1999: 143, cited in Csordas 1999 in Weiss & Haber ed. 1999). In phenomenological terms, sensory perception from this perspective was neither a thought nor mechanical process (the only alternatives within a Cartesian framework), but was instead a *bodily* intelligence, overcoming previous dualities between mind and body.

⁷ Notable here is the relative neglect of ‘embodied’ or ‘mindful’ bodies of interest to this study.

The body can therefore be seen not just as the mere 'object-body' of Descartes, but also arising out of the experience of Merleau-Ponty's 'lived-body' (Gold 1985; Frank 1990; Mehta 2011); what Williams and Bendelow have called the 'unified notion of the *lived*, experiential body...that serves not only as 'the existential basis of culture and self', but also of social institutions and society more generally' (1998: 208, *italics* authors). Sociologies of the Body have also built on wider critiques of the theoretical structure of the *Sociology of Health and Illness* and its links with biomedicine (Turner 1992) by challenging assumptions about its ontology and limits of its explanatory power, and involving the study of people's *interpretations* of their bodily experiences (Nettleton 2010, in Cockerham ed. 2010: 47-69). The field of medical sociology has provided fertile ground for the development of this approach, which is particularly appropriate for the study of the bodily experience of MBIs.

Gender is a crucial aspect of experiences of the 'lived body' and interpretations of that experience, and women's struggles over their bodies (particularly in terms of medicine) predate corporeal male preoccupations (Williams 2006). Feminist sociologists have made key contributions to challenging dualistic thinking, with a provocative explosion of work serving in the evolution of theoretical debates. In highlighting the significance of links between the body and the medical model, the dominance of this medical model and seeming objectivity of the body have become more open to question (Gabe & Monaghan 2013).

Since the early 1990s then the body has become a 'hot topic' in both empirical research and sociological theorising. It has been used variously as a resource for broadening the parameters of Nineteenth Century sociological thought, through a more critical questioning of the role of the body in relation to biology, and the juncture of nature and culture. The increase in the addressing of corporeal concerns has included a corresponding focus on embodiment and emotion when understood as the link between mind and body, embedded as they are in a biological substrate.

- **4. Embodiment and emotion**

- **4.1 Embodiment**

Illness, disease, pain, suffering and health comprise 'vibrant physicality' (Monaghan 2001), and are inseparable from 'lived bodies' as the site of experience, expression and meaning (Williams & Monaghan 2013 in Gabe & Monaghan ed. 2013: 66-67).

Sociological enquiry into embodiment can be traced back to the late twentieth century growth of phenomenology (Merleau-Ponty 1962), and has been sociology's attempt to understand what it really means to have, or 'be', a body, a concept historically taken for granted as a biological entity (Witz 2000). Sociology rediscovery of the body as a place where experience happens – differentiates embodiment from a sociology 'of the body' because it is about the experience of the being in a body and the body as process or development.

Attempts have been made to capture alternative forms of '*knowing*' through embodied knowledge, which is about knowing *how*, as opposed to the conceptual knowledge of knowing *that*. Non-conceptual forms of knowing have been argued to be anchored in the body, and to only come to life through practical engagement with the surrounding environment (Pagis 2010). The distinction between different forms of knowledge has been strictly observed in many sociological studies (Ignatow 2007). As asserted in phenomenological understandings of mental health, these understandings have been made possible through respect for subjective experience, asserting that the world is constructed and given meaning as it is experienced.

Sociology's neglect of the embodied dimensions of human existence has never been absolute, and the body has always had something of an 'absent presence' within the discipline (Shilling 2005). The biological body has thus not so much been lost sight of, but positioned within a broader non-reductionist and embodied perspective grounded in the experience of 'being-in-the-world' (Williams & Monaghan 2013 in Gabe & Monaghan ed. 2013: 66-67).

The work of Bendelow has been central to asserting the position of embodiment as lying 'ambiguously across the nature/culture divide', and providing a means of moving beyond traditional binary definitions (Williams & Bendelow 1998). Integrally linked to the body, emotions are at the heart of such efforts to go beyond binary thinking, and it has become common in psychological discourse to talk about emotions as 'embodied' phenomena (Barrett & Lindquist 2008). The body is thus examined as both experiencing and expressive (Freund 2008), with Bendelow's work forming a link between the mind and body (1998, 2010). Sociological contribution to theorising *across* the mind and body can be argued to help overcome an overly individualistic framing because emotions are shared, might be said to be contagious, and may be thought of as a feature of organisations as well as individuals.

○ 4.2 Critical theories of emotion

Barbalet argued that in the act speaking of and labelling emotions they can become objects, but that in doing so, they can become merely 'hypothetical constructs' (2002). In part because emotions are objectively hard to measure, the historic trend has been to see them as subjective, elusive, vague (Damasio, cited in Fox & Ward 2008). Definitions of emotions are thus culturally and societally diverse.

Plato's doctrine of the tripartite soul acted to form the preconception of a strict separation of emotions/passion from cognition/rationality, and encouraged the positioning of emotions as inherently irrational (Solomon 2000, cited in in Lewis & Haviland-Jones 2000; Sorabji 2006; Kirman et al 2009; Scherer 2011). Since the Enlightenment, rationality and reason have thus come to mean the transcendental capacity for pure logical thought, 'a capacity that is disembodied and has to be unemotional' (Burkitt 2014: 100; see also Howson 2013).

Similar to the 'absent presence' of the body within sociology, emotions have always had an implicit presence in the social sciences, but have tended to be dominated by psychological approaches that supported 'divisions which sought to 'separate mind from body, the public from the private, and the so-called 'reasonable' from the 'unreasonable' ' (Williams et al 1998: 747; Solomon 2000, cited in in Lewis & Haviland-Jones 2000). It was partly in reaction to previous dualist traditions that led to an 'emotional turn' in the social sciences, with emotions only emerging as a distinct focus of work within the last decade (Bendelow & Williams 2014). The 'sociology of emotions' originated mostly from the USA (Williams & Bendelow 1996), with a rise in academic interest in emotions (see Kemper 1990; Scheff 1994; Collins 2004 on collective emotional energy; Turner & Stets 2005; Röttger-Rössler & Markowitch 2009). A growing literature from both the social (Flam 2000) and natural sciences (Damasio 1999, 2005) also began to argue for emotion as *inherent*, rather than as *opposed to*, rational decision-making (Sieben & Wettergren 2010).

Sociological enquiry has allowed for the possibility that emotion can influence cognitive processes, 'or socially and culturally motivate apparently irrational acts' (Archer 2000; Theodosius 2008: 59). There have thus been calls for a fundamentally rethinking of Western (rationalist) epistemologies, and the constructing of different models of knowing and being demonstrating the 'mutually constitutive, rather than oppositional, relations between reason and emotion' (Jagger 1989: 156 in Williams & Bendelow

1998: 132). Relating to earlier discussions regarding psychosis, the emerging sociology of emotions has also helped to both highlight and problematise clinical and political distinctions between the disorders of thought, (i.e. 'serious' or 'real' mental illness which can reduce individual responsibility and require treatment that could be potentially coercive) and the 'less serious' disorders of behaviour and emotion (Bendelow 2010). Understanding the impact of these changes in the framing of 'emotional' problems affects the 'ways in which people understand, account for and interpret their emotional lives' (Chandler 2012: 446).

The so-called 'organismic' perspective (Gendron & Barrett 2009) is popularly understood through examples such as 'fight or flight' reactions involving surges of adrenaline, interpreted as fear or anxiety. Although biological accounts provide indicators of physical 'symptoms' – or feelings activated by cognitive awareness – they can largely ignore or under-emphasise the importance of socio-cultural meanings and the structural divisions that frame emotional expression. Social constructionist perspectives asserted the culturally constructed character of emotions, seeing them as 'part of conscious relations, actions and experiences of selves...actions we place in our world' (Williams & Bendelow 1996: 127).

The most influential contribution to evolving debates on the integration of psychobiological aspects of emotion as socially shaped 'ingredients' came from US American sociologist Arlie Russell Hochschild (1979, 1983, 1990, 2012). Drawing on the work of Goffman (1959) and Scheff (1994), Hochschild did not dismiss biology but saw emotions as biologically based but *socially* managed and structured (Simpson & Smith 2005). Hochschild countered the organismic model by arguing that emotions do not exist merely to be triggered by external activity, but also can *become* in social interaction (Reddy 2001). Hochschild also acknowledged psychobiological aspects of emotion when she explored their 'the signal function' in relation to danger (1983, 1990). This path-breaking 'interactionist model' offered a way of understanding feelings as part of the presentation of selfhood, as social expressions of the emotional state of an individual rather than as privately experienced, as well as the role of context in their embodied expression (Freund 2008).

As well as the interactionist model, another key contribution of Hochschild work specific focus in this study was addressing the paradox that emotions are both a feeling that happens to us, and yet also something we make happen through 'emotional labour', as well as being subject to management and training (1983). According to Hochschild,

'emotion work' or 'emotional labour', referred to the regulation of feelings and ability to be able to manage one's emotions to be appropriate in any given situation (1983). The suppression, repression or expression of feeling can be consciously controlled and open to rules and norms within social interactions. The possibility of this conscious control is what lay behind the development of the theories of emotional management.

The theory of emotional management is premised on the based on the belief that emotions can indeed be managed, and that they are dependent *on*, or acceptable *to*, cognitive processes. If emotions are seen as evolving processes in dynamic social contexts that can shape both implicit and explicit responses to them (Marinetti et al in Cowie et al 2011), each account of emotion and feeling has different implications for managing emotion (ibid; Maiese 2014). The focus of this perspective differs from Goffman (2012) in examining not how people try to *appear* to feel, but how people consciously adapt their feelings (Hochschild 1979, 2012, italics mine).

Hochschild's work focused mainly on social hierarchies within workplaces, but though this study is using her work to explore emotional dynamics within SPFT as a particular workplace, this theory is used to analyse the data in terms of the subjective management of responses to emotions which arise within individuals in day-to-day life, and the part that mindfulness practice plays in this process. Hochschild's seminal accounts of emotional labour and emotional management demonstrated the inherently social manifestation of emotion, and were formative in developing critiques of the discourse of emotional health and the implied need for this health to be managed, both terms of which are tied up in the growing service sector of the modern economy (1979, 2012)⁸. Her work however has not been without its critics, and in the context of a paucity of studies in this area some other notable studies are now examined.

○ 4.3 Engagement with Hochschild

The relationship between emotion and cognition is a complex and interdependent one (Freund 2008; Theodosius 2008; Williams & Bendelow 1998). Theodosius argued that in Hochschild's dealing with organismic theories of emotion, there lay an assumption that emotion always 'signals' or is stimulated by *external* social factors or psychological factors that require cognitive awareness' (Hochschild 1983; Theodosius 2008).

⁸ In terms of differing values and degrees of emotion work, Hochschild saw emotion work and management as expressly the work of women (Theodosius 2008; see also the work of Emily Martin on the intrinsically gendered nature of emotions (2010)).

Theodosius developed Hochschild's notion of emotion management by critically analysing her 'new social theory of emotion' (2008), and suggested that Hochschild's theory neglected emotion's relational aspects (see also Burkitt 1997, 2014) and prioritised external social factors over unconscious ones. According to Theodosius an analysis sensitive to unconscious processes of emotion *beyond* cognition would situate emotion management within an interactive and relational context, and the elusive areas of subjective consciousness and unconsciousness have become a challenge for reflection and sociological enquiry (Damasio 1999).

Another critical engagement with Hochschild has come from Archer in *Being Human* (2000). Archer took a realist view of emotions, seen as 'commentaries on concerns', responding to awareness of the wider world through an on-going inner dialogue connected to a sense of identity (2000). Archer's work both complements and develops Hochschild's notion of emotional labour and its relationship with self-identity. This work is thus useful in examining data regarding the benefits of group therapeutic spaces and conceptualising the self as a relational entity. Indeed, one of Theodosius's critiques of the work of Hochschild was her assumption of the essential nature of the self (ibid).

Moving 'beyond the rational' is a recurring theme of central importance in this study, in particular through a critical engagement with emotions in an organisational context. The management of feeling involving altering emotional states using emotional labour is apt for a consideration of emotions within organisations, though emotional management theory has had little application so far in health services research (Theodosius 2008).

This chapter now returns to an enduring contribution of Hochschild's work in bridging the biology-society divide, viewing emotions as multidimensional processes rather than just inner states, experienced in and shaped by interaction, and reproduced through social practice and language (Williams 1998). As Fox has highlighted, the way emotions are experienced is always dependent on the 'wider sociocultural frame' (1998).

○ 4.4 Relational understandings of the wider sociocultural frame

The importance of the wider socio-cultural frame in exploring emotions was widely acknowledged in early studies on the sociology of emotion by academics like Collins (1990), Kemper (1990), De Rivera (1992) and Scheff (1994).

Foucault's work asserted the central place of the body in 'the strategic configuration and historically contingent relations of power/knowledge within a society' (Williams & Bendelow 1998). The experience and expression of emotion are both based in the capabilities of the body. Shilling recognised the materiality of real flesh-and-blood bodies, arguing that human bodies are the *source*, *location* and *means* of society – i.e. bodies have an independent causal role in the creation of society, and are a site on which the structures of society inscribe themselves, as well as a means for positioning individuals within society in ways that may or may not foster human potentiality (in Alexander & Smith ed. 2005). The way people relate to and treat their bodies also shows the 'deepest dispositions of the habitus' (Bourdieu 1984: 190), as well as being both a form and expression of health capital (Phipps & Bendelow 2014). As Hochschild illuminated, sociological understandings of health and illness help to demonstrate the relationship between individuals and society, and take into consideration different individual's vulnerabilities and coping resources. The sociology of emotion can thus usefully draw upon health capital models to explain how individuals with less vulnerabilities and more resources could be less likely to perceive a particular circumstance as stressful (Bendelow 2010). Freund's work on the 'expressive body' and inequality has also been influential, with different modes of emotion being seen as differently embodied forms of empowerment and disempowerment in society; what Lyon termed the 'interrelation of body and society in praxis' (2008).

As suggested by contemporary studies of embodied sociology, 'it is not solely or simply a question of the body as a product of society or society as a product of the body, but of bodies both as shapers of and shaped by the society and social relations of which they are a part' (Gabe et al 2004: 63). The concept of embodiment as a basis for subjectivity in sociological enquiry thus crosses the boundaries between structure and agency, self and society, and most importantly body and mind (McNay 1999), asking how bodies are materialised in a social context, and within historical and institutional structures (Crossley 2013; De Jaegher 2013). Barbalet's work has been useful in the assertion of emotions as being situated in social relations, that then have the capacity to transform these relations, and that experiencing emotions can give rise to new ones (2002).

Following Bendelow's argument, another approach that has made a strong case for the integral nature of the mind/body/emotions/society is corporeal realism, through what Armstrong termed 'the delineation of corporal space' (2006: 868).

That the body is mindful, which all bodies can be said to be, is therefore not just an 'artefact of society', but has been argued to provide 'the active sentient basis of agency and meaning creation in relational and social forms' (Williams & Bendelow 1998: 208; McNay 1999). Like embodiment, a key aspect of enquiry into emotions is therefore that they should be seen as a *process* rather than a *state* (doing rather than being), a 'critical component of social interaction' (Howson 2013: 2).

Emotions mediate the bodily and social dimensions of lived existence, and the capacity to experience and respond in indeterminate and creative ways to the world depends on emotional processes. This extends the notion of the emotional capacities of the organism beyond the more restricted notions of the bodily bases of emotion to include its interactive and social dimensions, for it is through emotional processes that social life comes to be experienced, enacted, and thus embodied (Lyon 2009: 201).

Biology is important to medical sociology, which takes a non-reductionist approach to the human body (Bendelow 2009), but social context and the complex intertwining of emotion and embodiment are also crucial issues regarding the experience, distribution and consequences of stress. The social ontology of emotions as the 'missing link' capable of 'bridging mind and body, individual, society and body politic' (Bendelow 2009: 43), has also been explored by theories that have attempted to highlight the relationship between health, 'the phenomenological experience of illness, pain and suffering', and social structures. There has been convergence in sociological enquiry relating to the relationship between human embodiment and an inequitable social world, the social patterning of health and illness vis-à-vis class, gender and ethnicity, all of which impact on human bodies as socially located, lived and experienced (Gabe & Monaghan 2013). As such, theoretical frameworks that integrate the importance of social structure with emotion (Kemper 1990; Scheff 1994; De Rivera 1992), along with the social emotions approach which highlights the way sociocultural facts are continually embodied through emotional processes (Lyon 2009), may have most utility in approaching this data, though more research is needed to be able to state this with confidence.

In scientific discourse, stress has traditionally been theorised as being biologically located or within an individual's psyche. However, understandings of the mind-body interface have become increasingly subtle, including insights into physiological changes associated with stress. Indeed, Wainwright & Calnan have contended 'stress-related illness' to be one of the most commonly given reasons for work absenteeism

(2002). Moving beyond the biological also 'does not mean ignoring or treating as irrelevant' the 'physiological substrate' (Williams & Bendelow 1996). Bendelow's work has been pivotal in the rethinking of the role of emotion and stress in current patterns of health and illness across traditional divisions between physical and mental health conditions (2010). Her work advocates transcending not just the split between the mind and the body, but also the divide between the mind, body, and society (ibid).

More recent work in sociology on emotions includes analysis of emotions in organisations. This work has sometimes cited Hochschild but has not generally taken a specific critical perspective on her work, and has developed in part autonomously. A consideration of emotions within organisations is of central concern to the study of MBIs within SPFT.

○ **4.5 Emotions in organisations**

Bolton examined emotions in organisations and the emotion management skills organisational actors possess, taking an evolved analysis of emotional labour and alternative conceptualisations of organisational emotionality⁹ (2000). Bolton's work introduced a typology that offered 'a multi-dimensional conceptualisation of emotion in organisations' aiming to 'capture not only the frustration, dissatisfaction and exhaustion often associated with emotion work but also the humour, compassion and pleasure' (ibid: 88). This work recognised and responded to the need for new analytical frameworks.

Collective emotions have been conceived within an organisation or team as 'aggregates of emotional experience' between its members rather than 'group emotions' (Barbalet 2002: 5). This also relates to the idea of an emotional climate (de Rivera 1992; Barbalet 2002) that does not require all people within it to experience the same emotion, but is rather a group phenomenon consisting of the relationships between the people within it (de Rivera 1992). In very recent years this idea has been picked up again through studies of the production of knowledge as seen as an outcome of both the 'ethical' and emotional relationships scientists have with their peers and research participants (Pickersgill 2012):

⁹ Nursing has long established as occupation requiring a high amount of 'emotion work'. In *Changing faces: nurses as emotional jugglers* Bolton used Goffman's insights on the 'presentation of self' (1959) to show how nurses can juggle emotional demands whilst maintaining an acceptable 'face', set in the context of changes within the NHS (2000: 88).

'Exploring processes of co-production casts into sharp relief the essential emotionality of science; the relationships investigators have with their colleagues, work, and research participants pulse with emotion, potentially shaping in important ways the very kinds of knowledge that laboratories produce' (Pickersgill 2012: 579).

In retrospect this study might be read as part of a new effort to 'write in' emotions, building on that of Pickersgill on neuroscience and psychiatry (ibid), Grandley et al on *Emotional Labor in the 21st Century* (2013), and Waldron's *Communicating Emotion at Work* (2013), and is part of the 'writing in' of emotions (Bolton 2000) as applied to organisational settings. Compassion has become a growing area of focus within the NHS in terms of creating particular organisational climates and practices which can remind individuals of the values underpinning their work (Flynn & Mercer 2012). In contrast with emotionality, rationality within health care can be seen as practical, instrumental or institutional (Russell & Greenhalgh 2014), aspects which can arguably coexist with this growing assertion of the importance of compassion (an emotion in itself) within the NHS.

- **5. Conclusion; shifting theoretical foundations**

This chapter pulled together some key bodies of literature on diverse theoretical material, examining the historical context of 'the tendency to binaries' (Elliot 2007: 164), within the dominant traditions of biomedicine and medicalization. The continuing implications of this dualistic thinking were explored; from governmentality to the continuing Cartesian legacy remaining in mainstream psychiatry. Critical views of biomedicine have done much to challenge the power of the medical profession in public as well as academic circles.

These critiques have highlighted the need to address the body as well as the mind, and attempts to consolidate the proliferation of body studies have been both informative and set an agenda for future research (Williams 2006), emphasising that healthcare provision requires a paradigmatic understanding of the 'lived body', and the experiencing, sensing, agential self, with corresponding implications for therapeutic action (Curtis 2012). The concept of embodiment also has particular relevance to sociology's growing concern with corporeality. Ways of being in the world are embodied, as are emotional states. Embodiment, then, provides a crucial missing link between structure and agency (Williams 2006; Gabe & Monaghan 2013).

Hochschild (1979) highlighted the significance of emotion for understanding social life, and how it can be managed and shaped for social purposes (Theodosius 2008).

Emotions have been commonly defined as the part of consciousness (and *unconsciousness*) that involves feeling and in this way provides links between the mind, body and society (Bendelow 1998, 2010). Emotions have been described in the literature as being at the centre of human sociality (Flam & Kleres eds. 2015), as relational in nature, enabling individuals to situate and understand themselves in respect to the world around them (Crossley 1998; Archer 2000). Emotions, in other words, are feeling, thinking and evolving 'complexes', comprised of both embodied, corporeal, and socio-cultural dimensions (Burkitt 1997).

The transcendence of mind/body dualism provided by this area of enquiry has important implications for health and illness, and the integration of the biological and social (Bendelow 2014, cited in Gabe & Monaghan 2014). This focus helps to understand how mindfulness finds a space within the contemporary management of MH services. The following review chapter explores how the literature and theoretical foundations set out in this chapter can illuminate treatment and practice in mental health services.

CHAPTER 3. KNOWLEDGE AND PRACTICE IN MENTAL HEALTH TODAY

- **1. Introduction: influences on current practice**

This chapter thematically combines academic and policy-orientated material across medical sociology, psychiatry and science and technology studies (STS), considering a range of influences on current mental health practice and innovation within the broad context of biomedicine and medical pluralism. The regimes of 'evidence-based medicine' (EBM) and randomised controlled trials (RCTs) are key features of the current landscape of mental health, and are explored along with the significance of inclusion in National Institute for Health and Care Excellence (NICE) guidelines, and emphasis on cost efficiency. The growth of 'implementation science' is used to examine the growing desire for healthcare interventions to have a demonstrable impact, and the identification of barriers to this happening.

In the context of these discussions, this chapter then explores the impact of key changes within psychiatry, and the integration of biopsychosocial models into the organisation and practice of mental health services. A critical perspective is taken on the advent of forms of psychological therapies, in particular 'talking cures' and cognitive behavioural therapy (CBT). These critiques are informed by the evolution of value-based medicine (VBM), recovery and service user (SU) involvement, through a shift in sociological focus to actors' meanings, motivations, and subjectivities.

To understand the position of mindfulness-based interventions (MBIs) within contemporary mental health services, we must also understand the growth and appeal of what has been termed complementary and alternative medicine (CAM) in the context of evolving medical pluralism, and the shift from health education to health promotion within a policy-based focus on wellbeing. The related rise in critiques of therapeutic culture is then set alongside developing conceptions of the relationship between mind, body, and society, and the conditions allowing the emergence and integration of MBIs.

- **2. Innovation**

- **2.1 Evidence-based medicine**

MBIs as a form of innovation can be explored within the movement of EBM in terms of

the means by which it has gained recognition and legitimacy. Before exploring the position of MBIs in more detail, this chapter sets out sociological arguments concerning why all evidence is not regarded as equally valid, nor innovation a linear and uncontested process.

The first half of the 20th century saw different methodological approaches to measure and compare differences between groups to test treatment effects. The past two decades has then seen an increasing emphasis on healthcare decisions being based on the best available evidence from research, with the aim to 'provide the means by which evidence can be judiciously and conscientiously applied in the prevention, detection, and care of health disorders' (Haynes & Haines 1998: 274). This movement has been termed evidence-based medicine (EBM).

The need for organisational as well as individual change in implementing EBM has become increasingly recognised (Grimshaw et al 2004), as well as the 'notion that the evidence base for particular technologies and practices must be continually interpreted and reframed according to local context and priorities' (Greenhalgh et al 2004: 583). As May has highlighted then, a pertinent problem is the 'definition and production of the facts, who makes them and what their consequences are claimed to be' (2006: 529). Yet EBM is often portrayed as a value-free approach, justified through the theoretical claim that its methodological principles provide the best way to determine the effectiveness of interventions (Gupta 2011a).

Literature discussing EBM's focus on the quality of the scientific basis of healthcare highlighted that hierarchies of forms of evidence have been developed. As a means to acquire evidence within the EBM regime, the model of the double-blinded randomised controlled trial (RCT) is said to 'promote a specific model of rigor and analytic accountability' (May 2006: 513). RCTs are widely accepted as an objective scientific methodology that, when ideally performed, produce knowledge supposedly untainted by bias (Oakley 2000; Kaptchuk 2001). Since the requirement in the 1960s to demonstrate clinical efficacy and the development of RCTs as an industry, their use in testing and developing new healthcare treatments uses billions of dollars annually¹⁰. Along with their greater visibility however, the cost and importance of RCTs have led to concerns about their accuracy and underlying assumptions (Will & Moreira 2010; Cartwright 2011). Suggestions have been made that biased interpretation, publication,

¹⁰ The National Institute for Health Research (NIHR)'s budget for its first year in 2007 was over £60 million, and has provided £220 million of capital funding for the UK Centre for Medical Research and Innovation (UKCMRI) (National Institute for Health Research 2013).

and the influence of pharmaceutical funders has also undermined confidence in RCTs and raised awareness of their limitations (Goldacre 2006; Cartwright 2011).

EBM has also been subject to critiques regarding its implementation (clinicians do not always act upon guidelines), political appeal (through challenges raised by patient groups and clinicians about correct medications) and its epistemological underpinnings (in a hierarchy of evidence with RCTs at the top relying on statistical methods based on collective data) (Berg & Timmermans 2003; Mykhalovsky & Weir 2004; Timmermans & Mauck 2005). Critiques such as these have in part led to EBM being called a 'movement in crisis' in a recent British Medical Journal (BMJ) analysis (Oliver 2014).

Despite these challenges however, RCTs remain seen within the biomedical community as the 'gold standard' of EBM generation, and EBM continues to dominate contemporary healthcare, built on institutions such as NICE, the Cochrane Collaboration (a global network of researchers that gather and summarise evidence to aid healthcare decisions), recurring editorials in the BMJ and journals like the *Clinical Practice Guidelines Update*, *Evidence-Based Medicine*, and the *Best Evidence* CD ROM (Haynes & Haines 1998). Sociological concerns have also extended to the process of making evidence-based guidelines (EBG) (Knaapen 2013) which aim to valuate and address variations in clinical practice, often evidencing both clinical and cost-effectiveness (National Institute for Health and Care Excellence 2013). The relevance of questions of cost effectiveness and their links to forms of value are another important issue.

○ 2.2 Evidence-based guidelines and cost

Questions of value are of relevance to this study in terms of how MBIs are perceived and experienced amongst particular stakeholders. Defining and exploring value and valuation has been taken up in science and technology studies (STS) (Sismondo 2011), and classification work to qualify goods and agents has also been the subject of numerous studies (e.g. Bowker & Star 2000; Thévenot 2001).

This area of enquiry is both emerging and interdisciplinary, with valuation according to the Journal of the same name denoting 'any social practice where the value or values of something is established, assessed, negotiated, provoked, maintained, constructed and/or contested' (Doganova et al 2014). Guideline-making is collective work in which

core issues are related to the knowledge available, how this knowledge should be valued, which actors should be involved in the process, and how recommendations based on this knowledge justified (Moreira 2005; van Loon et al 2014). Berg and Timmermans have written extensively about the new technologies of EBG and EBM and their impact on health care professionals (2003), arguing that:

'Of all the kinds of standardisation attempts that have affected medicine in the twentieth century, evidence-based guidelines represent the farthest-reaching and most direct attempt to prescribe and preset the actions of health care professionals' (Berg & Timmermans 2003: 14).

The National Institute of Health and Care Excellence (NICE) is the central body charged with this implementation, and produces clinical guidelines for the National Health Service (NHS) in England, Wales, and Northern Ireland (National Institute of Health and Care Excellence 2013). The UK Department of Health commissioned the Institute to make healthcare recommendations on the basis of both cost-effectiveness and clinical effectiveness, and NICE was given a remit to develop public health guidance in 2005 developed from collated research evidence (Kelly et al 2010).

Though not *always* part of EBM, cost is a central concern, especially at NICE and because clinical guidelines give advice on which treatments to administer and when, they are ideal means by which to promote cost-effective clinical practice, and have come to be seen as a brand or stamp of approval in these terms (Will & Moreira 2010). The use of a systematic review underlying at least some guidelines also serves to legitimise their credibility (Knaapen 2013; van Loon et al 2014).

The valuation of MBIs is of particular significance to the inclusion of MBCT within EB guidelines, and the basis on which their inclusion has been made (or could be made in the future). The institute has been applying a cost-effectiveness threshold of between £20,000 and £30,000 for a long time (Wonderling et al 2011). What NICE's threshold represents, and other factors that should be considered as well as cost, has been the subject of much discussion, with the balance between cost-effectiveness and clinical outcomes of increasing pertinence (McCabe 2008; Wonderling et al 2011). In terms of choosing outcomes on which to base EBG, Quality-Adjusted Life Years (QALYs) are currently central to NICE evaluation as the primary health outcome, considering the impact of alternative interventions on both overall quantity and quality of life, and

allowing comparative assessments of cost¹¹ (Räsänen et al 2006; Soares 2012).

NICE guidelines and valuation threshold are not unproblematic, as shown in the case of the provision of the cancer drug Revlimid (Dyer 2008). NICE's initial refusal (then overturned after an agreement to share the cost with the manufacturer) to fund this new treatment for myeloma was damned by the High Court as a decision that 'no reasonable authority could have made on the application before it' (ibid: 337). This literature shows that neither inclusion in NICE guidelines nor participation in an RCT gives a particular drug or intervention scientific legitimacy, and national priorities determine the context for implementation, with the process also influenced by localised interactions and professional discretion, which in turn influences responses to guidelines (Spyridonidis & Calnan 2011). Integral then to the regimes of EBM, RCTs and NICE are positions and practices around collective thought and localised responses to the implementation of national guidelines (Karuza et al 1995), to which this chapter now turns.

- **3. Implementation: enablers and barriers**

- **3.1 Context and clinical experience**

Previous literature on innovation in healthcare focused on enabling factors such as funding for research (Mittmann 2004), and a strong evidence base (Haynes & Haines 1998; Mykhalovsky & Weir 2004). Barriers to innovation have also been identified such as the requirements of EBM, the variation and availability of empirically-supported treatments (Spring 2007), and stakeholder resistance (Bhattacharjee & Hikmet 2007; Birken et al 2012). A recent survey carried out in the US found that many patients were not receiving treatments that were empirically supported, and that therapists either may not update their knowledge of research, or might prefer to improve their practice using their clinical experience rather than research findings (Gyani et al 2014). Other studies have shown that few guidelines lead to consistent changes in provider behaviour, with the collaborative nature of medical work needing to be taken into consideration (Timmermans & Mauck 2005).

The development of the field of implementation science has been central to developing

¹¹ The preferred measure for estimating QALYs in adults is the EuroQol-5D (EQ-5D) questionnaire, a preference-based measure classifying health states. Patients are asked to report descriptions of health status (Wonderling et al 2011).

and disseminating models for critically appraising evidence (Greenhalgh 2004; Proctor et al 2009). Greenhalgh et al's review asked how innovations in the delivery of health services and organisation are spread and sustained, identified gaps in knowledge, and suggested a transferable methodology for the systematic reviewing of health service policy and management (2004). A central concern of this paper was highlighting that the benefits of evidence generation will not be felt unless analysis is focused on how this evidence is put into practice, as well as the role of experience.

The organisation within which therapists work has also been demonstrated to impact attitudes toward working practices. This focus on contextual factors is central to enquiry into the management and diffusion of innovation across multiple disciplines¹² (Thompson et al 2007). Work on the diffusion of innovation has also examined social networks and their role in disseminating clinical advice (Armstrong & Ogden 2006). Of relevance to these varied factors has been the role of opinion leaders.

○ 3.2 Opinion leaders

Opinion leader theories have been mainly applied within media sociology, and by the late 1960s were hailed as one of most important formulations in the behavioural sciences (Arndt 1967).

Opinion leaders are people who are seen as likeable, trustworthy and influential. Because of their influence, it is thought that they may be able to help and persuade healthcare providers to use evidence when treating and managing patients (Flodgren et al 2011: 2).

Opinion leaders have been described as individuals with a certain influence (either positive or negative) on the actions and beliefs of their peers, can broker information across the social boundaries between peer groups (Burt 1999), act as gatekeepers for interventions, and help change social norms (Valente & Pumpuang 2007). Opinion leaders can be distinguished between *expert* opinion leaders whose influence is exerted through status and authority, and the influence of *peer* opinion leaders through their credibility and representativeness (see Fitzgerald et al 2002 and Locock et al 2001, italics mine). It is the latter group of interest in this study. These individuals have been argued to advance evidence-based practice (ibid), but their effectiveness varies both between and within studies, with either a positive or negative influence

¹² Significantly, concepts used within this literature appeared 'to be based on the premise that interpersonal contact improves the likelihood of behavioural change when introducing new innovations into the health sector' (Thompson et al 2007: 691).

(Greenhalgh et al 2004). In a review by Flodgren et al, the role of the opinion leader was also not clearly set out in many studies, highlighting difficulties in identifying how to optimise their effectiveness (2011).

Successfully influencing norms and practice is reliant on both the levels of trust and social capital in the individuals concerned, as well as having access to best-evidence (Brown & Michael 2003; Flodgren et al 2011). Studying the role of social capital in innovation diffusion within healthcare also establishes a conceptual link with broader inequalities. As Locock et al highlight, 'what makes someone a credible and influential authority is derived not just from their personality and skills and the dynamic of their relationship with other individuals, but from other context-specific factors' (2001), such as access to funding, the broader organisational culture, and the demographic of the patients within their remit. In terms of the significance of an organisational focus and the strategic work of the actors within them, in the 1980s another theoretical approach went on to explore the significance of expectations and hope in science and technology of innovation.

○ 3.3 Expectations and hope

'Future expectations and promises are crucial to providing the dynamism and momentum upon which so many ventures in science and technology depend. This is especially the case for premarket applications where practical utility and value has yet to be demonstrated and where investment must be mobilised. The need for a better analytical understanding of the dynamics of expectations in innovation is both necessary and timely' (Brown & Michael 2003: 3).

Literature exploring the role of expectations and hope is of relevance in forming a link between the present and future value of MBIs. A sociology of expectations has raised questions about the role of expectations and hope in shaping change and innovation, innovation argued to itself be an 'intensely future-oriented business with an emphasis on the creation of new opportunities and capabilities' (Borup et al 2006: 285).

Expectations have been argued to vary according to key factors such as whether interpersonal relationships are established or emergent, as well as the closeness of the actors involved in terms of knowledge production, and the mobilisation of resources (Brown & Michael 2003; Borup et al 2006).

In attempts to address long-standing debates on the relationship between given facts and future values, the balance between truth and hope has also been a recurring theme in recent years (Kitzinger & Williams 2005; Moreira & Palladino 2005), with expectations, enthusiasm and hope for a particular intervention all shown as needing

careful management in different clinical contexts (Will 2010). Brown & Michael have also highlighted the importance of accountability and balance of 'hope against hype' (2003: 3).

Despite the complex and relational dynamic of expectations, some areas of innovation are still argued to be championed and led by certain individuals (Markham 1998; Davies et al 2000). There has indeed been a long held wisdom in healthcare that 'champions' are a key aspect of organisational change, and integral to both opinion leader and expectations theory is the growth in studies of the role of champions in the management of innovation and as a key aspect of organisational change, particularly in the first phases of adoption of innovation (Hendy & Barlow 2012). Greenhalgh et al have argued that the adoption of an innovation may be more likely if key individuals within an organisation are willing to support the innovation, though 'there is very little direct empirical evidence on how to identify, and systematically harness the energy of these individuals' (2004: 603).

In work building on that of Harrison and Mort (1998), Sibthorpe et al identified three key themes in a study of the findings of five major studies of the sustainability of primary health care innovations; the importance of social relationships, champions and networks (2005). These findings all involve the sharing of information as well as building of hopes, and the common emphasis of the importance of social relationships for innovation highlights the very *human* nature of organisational change. As discussed in Chapter 2, Barbalet argued that emotions are experienced in the body as subjective feeling and part of a transaction between one person and another, and that emotions are therefore inherent to social relationships¹³ (2002). Identified as relationally based in Chapter 2, emotions can thus be conceived as of central importance to the relationships discussed by Sibthorpe et al as central to healthcare innovation (2005). This relates closely with the literature on diffusion of innovation (Greenhalgh et al 2004), and the sustainability of primary health care programmes, with critical factors for sustainability including social relationships, networks and champions (Sibthorpe et al 2005).

As well as factors which enable innovation and responses to evidence, it is important to consider the barriers to the implementation of evidence. Studies of healthcare organization and implementation have also drawn on the concept of 'barriers' to

¹³ Barbalet's discussion of emotion as the 'experience of involvement' is also relevant in terms of innovation (2002).

discuss a range of contextual, organizational and social factors impeding the adoption of new practices or technologies.

- **3.4 Implementation barriers**

In the literature on EBM, barriers to implementation are understood as complex and include multiple factors beyond the control of both the patient and practitioner (Haynes & Haines 1998; Grol & Wensing 2004). Healthcare interventions can require considerable investment with delayed benefits, and while knowledge about what to change is relatively simple to impart, the more difficult task is creating the culture and enthusiasm required to deliver this change (Imison et al 2015). It is not easy for clinicians to find, interpret, and apply current best evidence, as well as attempting to ensure it is applied at the right time (Haynes & Haines 1998; Rubin & Bellamy 2012).

The sense that it is hard to move from evidence to innovation has informed repeated efforts to think again about evidence for healthcare, including the *What Works Network* (Gov 2014), Nesta's *Making Evidence Useful* (Nesta 2014), the Royal Society for the encouragement of Arts, Manufactures and Commerce's (RSAs) *Action Research Centre* (The Royal Society 2014), and a recent report by the Kings Fund (2015) *Transforming our healthcare system; Ten Priorities for Commissioners* (Imison et al 2015). However progress made in connecting research into practice (as well as practice into research) may be undermined by limited resources. The language of 'barriers' can also be used without due consideration for the complexities of the process of implementation.

In exploring how MBIs found a space and legitimacy within SPFT, discussions of EBM, NICE, and varied factors influencing innovation should be seen in the context of the development of a new diversity of public health-service provision. The impact of the theoretical frameworks set out in Chapter 2 will now be explored in the context of changes in organisation and practice in psychiatry and mental health service.

- **4. Contemporary mental health**

- **4.1 Changing service provision and focus**

All these factors affect different parts of medicine in similar ways: however there are some challenges which are more specific to mental health. To explore the position of

MBIs as a therapeutic intervention within mental health more broadly warrants an exploration of MBIs within the evolving story of psychiatry as a discipline.

This history starts in the 18th Century following the closure of large singular psychiatric institutions, psychiatry then transformed during the twentieth century (Busfield 2000), with service provision shifting towards a more heterogeneous provision through what came to be called 'care in the community'. The nature of power relationships between psychiatric professionals and patients changed alongside the physical structures of care. Though the large asylums and mental hospitals of the 1980s and 1990s had closed, services for those with a serious mental illness (SMI) were still separate from general medicine, with specific strategies deployed with the stated aim of rehabilitating psychiatric patients within a community environment (Bendelow 2010).

A large body of sociological literature has explored the expansion in the amount of psychotherapists after the two World Wars. These therapists attempted to respond to the number of distressed people (Pilgrim & Rogers 2010), leading to an increase in numbers of people seeing their GP and being treated for what were medically defined as psychiatric problems. In the diagnosis and treatment of personality disorders and neuroses, psychiatric services since have tended to focus on a 'cure' as well as behaviour management¹⁴. The demographic of patients has also changed, with the average age of users of psychiatric services now being older, with more of the middle classes and women represented (Busfield 2000).

Impacting on these developments has been the growth in size and power of the global pharmaceutical industry ('big pharma'), leading to an increased consumption of prescription psychotropic medicines alongside (and instead of) psychotherapeutic treatments¹⁵ (Goldacre 2012). The pharmaceutical industry performs extremely well under the system of EBM, and can be privileged over 'talking cures' (explored below) for this reason. Yet as set out in Chapter 2, the evolution of healthcare provision has also included talking therapies, most recently those emphasizing cognitive approaches.

14 The 'psy' disciplines have also taken an active role in managing the boundaries of understandings of mental health (Rose 1989, 1992).

15 The USA and Europe being the largest market of consumers and commercial pharmaceutical companies with profit-making motive such as GlaxoSmithKline and Pfizer (Goldacre 2012).

○ 4.2 Talking Therapies

One of the central pillars of the rise of talking therapies within psychiatry was the 2006 Improving Access to Psychological Therapies (IAPT) initiative, led by Lord Layard of the London School of Economics (LSE). The IAPT programme aimed to provide new forms of mental health services offering evidence-based psychological treatment for adults with depression and anxiety rather than purely medication, and has been the subject of much academic and policy debate (Summerfield & Veale 2008; Clark et al 2009; Improving Access to Psychological Therapies 2013).

One aspect of these debates has been the economic benefits of the programme. As Professor Mark Williams, Director of the Oxford Mindfulness Centre Oxford University has stated:

'Layard's justification for the Improving Access to Psychological Therapies programme was that, even with a 50% response rate, it pays off for the Department of Work and Pensions. That's because those people will work for one or two more months more, so the cost of the therapy is more than covered by its economic benefits' (2010: 54).

Psychological technologies have been argued to tackle long-term unemployment with a limited number of sessions of CBT (Pilgrim 2008), with CBT assuming that irrational beliefs and/or thoughts can lead to emotional difficulties or particular behaviours (Anderson & Brownlie 2011; Knapp et al ed. 2011). There is also evidence to support the efficacy of CBT in tackling somatoform conditions (mental illnesses that cause bodily symptoms), and their underlying psychological causes (ibid). These arguments in part encouraged the UK government at the time to increase the availability of psychological therapies through IAPT. A 2013 conference report quoted Paul Burstow MP - Care Services Minister - stating that 'by 2015 every patient in the country should be able to get timely access and real choice of proven psychological therapies' (New Savoy Partnership 2014).

Debates on the expansion of talking therapies have addressed their ideological premise, questions of effectiveness, cost-benefit, access, and a focus on a 'cure'. Walters et al (2008) found that compared to self-help or medication, people with mild-to-moderate psychological distress appeared to prefer informal support and sources of help involving direct human contact. These arguments highlight the ambiguous position held by talking therapies encompassing both of the therapeutic approaches of human contact *and* self-help.

The IAPT programme has been an important factor in the increasing use of talking therapies alongside, or as an alternative to, pharmaceutical treatments. Although not in itself new either as an entity or term, Cant and Sharma's 'new medical pluralism' is often used to describe this growing array of mental and physical health services in the evolution of CAM (1999, 2004; Scambler 2002; Saks 2003). This plurality has been facilitated by market reforms in the health service, the underlying discourses of which are now explored.

○ 4.3 Choice and Consumption

Indivisible from the position of MBIs as part of a growing plurality of therapeutic options, is the current emphasis on choice and consumption. The changes within the NHS outlined in Chapter 1 were initially associated with the neo-liberalism of the Thatcher years, but the Conservative, Labour, and Coalition governments since have progressively introduced internal markets, reframing patients as consumers (Bishop et al 2011). Crossley (2006) is among many who have written critically about these changes, and the ambivalence of opportunities offered by these changes for smaller providers to bid for contracts in a more open market (see also Bell & Figert 2012; Rogers & Pilgrim 2014).

The practices of healthcare professionals and institutions have been considered in this study with the aim of understanding how they act to form 'the ways that individuals and institutions can think, speak, and conduct themselves', and 'the ways in which rhetoric of healthcare reform opens up or creates opportunities for new subject positions available to providers, the state and the service users' (Speed 2011, cited in Rapley et al 2011: 132). Through this modernist rhetoric health status is framed as something for which individual consumers are expected to take responsibility, as well as supporting competition between different providers of healthcare (ibid).

Through these developments, the fostering and promotion of choice and consumption, with an emphasis on the achievement of personal happiness and fulfillment through self-discovery, assessment, and management, thus become common in many UK healthcare policies (Harris et al 2010), and the subject of critical perspectives on the rhetorical nature of such choice in terms of socio-economic status. Individuals in modern society increasingly look to reduce feelings of anxiety and powerlessness by exercising 'rational' choices rather than passively accepting their fate (Griffiths et al

2006), with the concurrent implication is that knowledge accountability comes from increased choice. In this sense, 'consumerism, rather than resisting the clinical gaze, can be said to be a subject position that works *with* medicine, with less potential for resistance' (ibid: 134).

The last decade has seen a transformation in the ways in which the UK government and policy makers understand human decision-making and behaviour. This transformation (often referred to as the Behaviour Change Agenda) contains two key insights: first, that despite human behaviour being a fundamental goal of public policy, public policy makers have found changing long term patterns hard (particularly regarding healthy living). Second, that human behaviour is more emotionally oriented than suggested through traditional theories¹⁶ (House of Lords 2011). This emotional engagement is encouraged by companies such as international food and drink corporations to establish health-related consumption not regulated as medicine (Saukko 2013). These so-called 'technologies' occupy a space between the highly regulated domain of medicine and a consumer market that is less regulated (ibid).

As part of the evolution of markets reform and consumer choice, people are presented with a landscape of ever-increasing and changing information, often through the medium of information communication technology (ICT), often with unclear origins, content, and value (Haynes & Haines 1998). The availability of books, apps for 'mobile health', health-related information on the internet and online courses within a market – often termed 'e-health' - have all affected how we think we *do* health in today's society (Lupton 2015; Lucivero & Prainsack 2015), with the case made that the growth in use of ICT has facilitated the rise in emphasis on self-management for varied health conditions as part of a wider government emphasis on wellbeing (Ryff 1989; Ryff & Singer 2008). The World Health Organization (WHO) has defined 'e-health as the use of information and communication technologies (ICT) for health' (2012). The increasing popularity of CAM forms a challenge for sociological enquiry in terms of the dominant associations with e-health, consumerism and the market along with the focus on healthcare (Doel & Segrott 2003).

16 The UK RSA Report: Transforming Behaviour Change (2011) argued for a more sophisticated understanding of the relationship between social challenges, behaviours and the functioning of our brains (The Royal Society 2014).

We have seen that sociology has examined progress made towards more humane and person-focused treatments, and the development of psychological therapies and evolution of CAM has been part of this shift. The work of Carol Ryff has for many years been highly influential in the field of wellbeing; in particular the argument that dominant measures of psychological well-being have little theoretical basis, and that purpose in life, personal development, positive relations with others, and autonomy, are not related strongly to prior assessment indexes (1989, 2001; Ryff & Singer 2008; Keyes 2010).

As Chapter 2 explored, within psychiatry numerous paradigms have been ‘constantly in conflict’, and discussions of the current state of psychiatric care are indivisible from its challenging critiques (Reznek 1991). The growth of CAM can be discussed as such a challenge.

- **5. Challenges to dominant discourses**

- **5.1 Complementary and alternative medicine**

The multiple forms of CAM have been termed a ‘significant medical, economic and social phenomenon’ (Barcan 2011: 2), comprising of a large and heterogeneous array of both therapeutic and diagnostic approaches. The underlying philosophies of CAM practices often differ from biomedicine in terms of exploring ‘holistic’ or ‘naturalistic’ models of the body. In contrast to the biomedical conception of pathology as a result of locatable internal or external factors, CAM approaches take a holistic view of the body, with illness considered in relation to the psychological, spiritual and social (Ernst et al 2008). These factors typically involve ‘utilising the body’s capacity for self-repair and recognising the need to restore balance, rather than addressing a disease process or preventing particular symptoms from developing’ (Hardey 2013, cited in Gabe & Monaghan 2013: 175).

In Western societies since the 1960s there has been a significant growth of public interest in CAM for the treatment of depression and other psychological (and physical) disorders (Baarts & Pederson 2009), and there has been a substantial growth in empirical studies in the last 15 years exploring CAM usage as well as patient experience (Wilkinson & Gale 2015). Roughly half of the population of industrialised countries now use some form of CAM regularly, and the number of practitioners now equals that of registered GPs in the UK (ibid), with users spending on average £13.62

on CAM per month (an annual expenditure of £1.6 billion for the UK)¹⁷ (Ernst & White 2000; Posadzki et al 2013). Reasons for the popularity of CAM are complex and vary from therapy to therapy and from one individual to another (i.e. a patient with AIDS will have other motives than someone who is 'worried well') (Ernst 2000). Income, education, gender and health status are also powerful predictors of the use of CAM (Bishop & Lewith 2010). In a UK-wide survey in 2000 the main reasons for trying CAM were its relaxing effects, perceived effectiveness, and criticism of conventional medicine (Ernst & White 2000; Wiese et al 2010). A telephone survey on the use of CAM in the UK showed massage, herbalism, reflexology, aromatherapy, acupuncture, and reflexology to be among the most popular (Ernst 2000).

CAM is argued to produce 'derivative benefits such as a fresh and sustained sense of bodily responsibility that induces new health practices' (Baarts & Pederson 2009: 719), with practitioners said to be engaging in 'relations of restoring...evoking a sense of equilibrium, well-being and renewal' (Scambler 2000: 131). Barcan viewed CAM as consisting of more than just differing medical techniques, but rather as '*cultural practice* bound up in new forms of bodily understanding and perception and new conceptions of selfhood' (2011: 3, italics mine). Related to critiques of psychiatry touched on in Chapter 2, CAM may have risen in number and popularity in response to the individuated need for solutions to problems often presented in therapeutic discourses as emotional, e.g. 'stressed out' 'burnt out' 'midlife crisis', and personal inadequacies, guilt feelings, conflicts and neuroses (Furedi 2003). Consumer demand has also increased in countries where biomedicine dominates the health care system. The growth of CAM has been discussed in the literature as under the 'modernisation agenda'; opening up of the healthcare market to 'any willing provider', prevention, self-management, and a focus on compassion (Wilkinson & Gale 2015). An example of this is a recent report by NHS England *Compassion in Practice- Two Years on* (2014) (NHS England 2014) discussed compassion as the focus of the new three year strategy for staff in care, nursing, and midwifery.

As Hardey has described, during the nineteenth century 'an epistemological divide was established between biomedicine and CAM' (2013, cited in Gabe & Monaghan 2013: 175). However, boundaries between conventional and 'alternative' medicine however are neither as stable or impermeable as often presented (McHale & Gale 2015, cited in

17 Data on prevalence rates such as this drawn from CAM surveys should be treated with caution, as it can be assumed that it may be predominantly proponents of CAM that respond to surveys such as these (Posadzki et al 2013).

in Gale & McHale 2015), and complementary and alternative medicine', is a rather 'indecisive term' given the practical (and sociological) difference between mutually enhancing complementarity, and a practice being positioned as 'alternative' to biomedicine.

There have been many attempts to sub-divide CAM (Ayers & Kronenfeld 2010), and as is the case with biomedicine, much diversity exists within, as well as between, practices, and definitions and alliances, which also evolve over time (Gale 2014). In the use of the acronym the term 'alternative' is still regarded with suspicion (see Ernst (2002) for homeopathy and evidence-based research controversies (Bendelow 1999). Some complementary treatments such as chiropractic and osteopathy however have become integrated into mainstream health services, sometimes even free of charge¹⁸, with arguments made for this being a tactic offloading of patients with medically unexplained symptoms (MUS) (Cant & Sharma 1999; Isaac & Paauw 2014).

An exclusive emphasis on biological aspects of healing has provided the West with advanced diagnostic and therapeutic approaches, but questions remain regarding how biomedicine has responded to challenges raised by CAM to its social and epistemic authority and borders, and how therapeutic approaches such as MBIs are evaluated within these discussions. Saks has argued that the increase in CAM and growing number of claims to knowledge in this area can be seen as a challenge to biomedical authority (2003). However, the position of the British Medical Association (BMA) on CAM has been moving away from one of hostility (Saks 2003; Scambler 2005).

'The history of the relationship between CAM and mainstream health care has shifted from the early days of pluralism, through hostility and exclusion, to one of 'grudging acceptance, and a 'tacit acknowledgement and in some cases open endorsement by biomedicine for a number of forms of CAM practice, largely driven by the popularity of CAM to consumers in our increasingly market driven health care system' (Wiese et al 2010: 326).

This acknowledgement does not however mean as claimed that the hierarchical division between 'scientific' and CAM has collapsed (Scambler 2005; Jablensky & Sartorius 2008). Cant and Sharma have also contended that although there has been a multiplying of 'legitimate' health care providers, biomedicine itself has remained dominant (2004), and has re-stratified in various ways in response to the challenges of reforms and growth of CAM (Derkatch 2008). The term CAM remains popular within

¹⁸ Hence the at times arbitrary distinction between therapies that either 'complement' or are 'alternative' to mainstream biomedicine.

the policy and popular arenas, but Gale has argued that this terminology maintains its borders and hierarchy, and is itself a product of historical social construction (2014: 806). Relevant to the nature of this knowledge, Derkatch has examined what she termed the 'rhetorical constituents of biomedical boundary work', including its historical-professional, epistemological, clinical, and popular dimensions (2008: 3). CAM from this perspective can be seen as scientific boundary work that acts to 'shift, and then seek to fix, the boundaries between what counts as proper medical science and what does not' (ibid). The legitimacy of CAM also remains strongly related to the adherence of these therapies with the requirements of EBM¹⁹ (Hardey 2013, cited in Gabe & Monaghan 2013).

One sociological contribution has been to provide a historical perspective on these shifts (Gale 2014; Weise et al 2010). Another has been to chart the complexity of use of user experiences of CAM in mental health services. Ernst (2000) has expressed concerns that the rise in CAM represented a 'flight from science propagated by enemies of reason' (MacArtney & Wahlberg 2014: 114). MacArtney & Wahlberg argued however that CAM users have been positioned as irrational, ignorant, or immoral in explaining its use, and that this problematisation misrepresents the complexity of reality, with users perhaps more discerning than are represented (ibid). An important aspects of this work however has been the approach taken by the users of CAM, who can tend to make choices based on perceived therapeutic effectiveness and pragmatism rather than scientific evidence or philosophy (Gale 2014). Wiese et al further argued that the shift to 'grudging acceptance' through alignment with EBM has generated new forms of knowledge (2010).

Inherent to debates over the particular contribution of CAM, a central aspect of the critiques of biomedicine, psychiatry, and plurality of therapeutic approaches, is the assertion of an alternative set of values.

○ 5.2 Values-Based Medicine

Just as we need evidence-based medicine because of the increasing complexity of the evidence underpinning medical decision-making, so, increasingly, do we need values-based medicine because of the increasing complexity of the values underpinning medical decision-making (Fulford 2008: 12).

¹⁹ Debates regarding the regulation of CAM relate to those in the rest of the healthcare, and as McHale & Gale highlight, slow progression towards regulatory oversight does also not in itself 'fully determine or resolve the characteristics of the profession' (2015, cited in Gale & McHale 2015: 375).

Negotiating values is a common feature of clinical practice, and the best clinical decisions based on an engagement with the *non*-technical dimensions of clinical practice such as values, relationships, and meanings (Bracken et al 2012, *italics mine*). The work of Fulford et al has been a key resource within an interdisciplinary field of philosophy of psychiatry (2008), in highlighting both that values encompass much more than the ethical problems often seen in the medical field, but also the important feature of values as 'prescriptive' or 'action guiding' (ibid). VBM has been defined by López-Ibor and López-Ibor as 'the theory and practice of effective healthcare decision-making for situations in which legitimately different, and hence potentially conflicting, value perspectives are in play' (2010: 1358). These potential conflicts have included EBM versus VBM, though Fulford saw it as possible to incorporate patients' values into medicine in ways complementary to EBM (2011).

The influence of VBM on mental health practice can be seen in the national framework developed by the National Institute for Mental Health in England (NIMHE) (Study More 2014). This framework is now used as the basis for specific initiatives in policy and service development that are concerned with more effective and patient-centred care (Fulford 2008).

○ 5.3 Rise of recovery and user involvement

Sociology has contributed significantly to research into putting patients at the centre of clinical encounters, and therapeutic approaches that take this approach. This focus can be seen as alternative form of value. Patient values have been asserted largely through service user movements.

Since the 1980s the notion of 'recovery' has become central to the aims for progress in mental health policy. Theories of recovery are rooted in diverse aspects of mental health development; social inclusion, service user involvement, person-centred approaches, self-management approaches, and radical political pressure groups. The term itself however remains contested, and can cause confusion through its association with 'cure' (Deegan 1996²⁰). This confusion has not been helped by the multiple ways the concept has been used at the same time as 'an approach, model, philosophy, paradigm, movement, vision and illusion' (Davidson 2005: 26). MBIs are

20 Patricia Deegan's active vocalisation of her lived experience of schizophrenia played a pivotal role in asserting the empowerment of people diagnosed with a mental illness (1996).

positioned in this study in the context of the rise in these critical movements.

In conjunction with other initiatives promoting the non-technical dimensions of healthcare explored in Chapter 2 such as the biopsychosocial model (Double 2002), since 1997 there have been progress towards accountable and patient-centred services, and establishing formalised involvement of service users in healthcare services. These initiatives variously referred to as ‘patient and public involvement’ (PPI), ‘service user involvement’, ‘user involvement’ or ‘lay involvement’, encouraged individuals and interest communities to take a stronger position and assert their voice both within the NHS and in health and social care research²¹ (Pilgrim 2008).

Recent studies have also reacted to pressure to the concerns of the recovery movement: to respond to the priorities of patients and mental health service users, for an increase in SU involvement in trial design and analysis, for RCTs to be open and transparent to patient scrutiny, and for research to be understandable to a lay population (Leung et al 2004; Ward et al 2010). Rabeharisoa & Callon have gone so far as to argue for the involvement of patients in research within a new regime of knowledge generation (2002). Regarding the shaping of services rather than treatment decisions has been the patient and public involvement (PPI) model. PPI takes a different position from the survivorship inherent to the concept of recovery, and emphasizing the empowerment of users across healthcare systems.

Debates surrounding PPI have focused on its ethical, social and political aspects, and patients and many clinicians belief in an active programme of participation involving patients and the public (Williamson 2014). PPI remains a contested area, and healthcare professionals have expressed concerns that patients may involve very personal issues in discussions of research development, and on the part of those patients lacking confidence in interacting with healthcare professionals (Stewart et al 2011).

Another form of user involvement is the expert patient programme. The concept of the ‘Expert Patient’ (EPP) began in US in the 1970s, with ‘*The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century*’ (Department of Health 2001) then published in the UK, followed by the launch of the Expert Patient project

21 The National Institute for Health Research in England has made PPI central in its development (Stewart et al 2011).

with the setting up of lay-led self-management programmes for long term conditions²² (Davidson 2005).

Self-management can be viewed in two ways: as a portfolio of techniques and tools to help patients choose healthy behaviours; and a fundamental transformation of the patient–caregiver relationship into a collaborative partnership (de Silva 2011).

Self-management is used as a term in the expert patient programme, which also incorporates ideas from the recovery movement. As a term it has been gaining momentum as a high profile policy initiative (Bendelow 2014), and is claimed to be a reflexive and holistic approach that attempts to use an individual's lay expertise to develop autonomy and self-determination in health maintenance and illness prevention, providing a term understandable by most people in the mental health community (Davidson 2005).

As well as questions being raised surrounding Fulford's optimism of the impact of VBM as an internal reform movement, questions remain as to what extent SU involvement and PPI as patient-driven movements are tokenistic (Goldacre 2006). In an article exploring the notion of recovery, Pilgrim explores some of the nuances around the emergence of the SU movement, arguing that:

Despite the new discourse of listening to users' views, a tension remains because of privately held and so undisclosed professional assumptions about patient irrationality. This implies that private pessimism about user-involvement might co-exist with optimistic public rhetoric in professional mental health work (2008: 299).

In another recent critical analysis, Tierney et al also found that few papers provided a clear working definition of patient involvement, with the majority of methodologies not qualifying as research with service users (2014). In terms of critiques over terminology, 'self-management' can sound mechanistic, and along with discourses of 'resilience', can be problematic as effects of such resilience may not overcome the effects of socio-economic surroundings²³ (Sameroff & Rosenblum 2006).

In an important corollary to these critiques, rather than users being passive recipients of this discourse, Ewan Speed examined how discourses about mental health services

²² The EPP is a 'free six week self-management programme for people with any long term health condition and aims to equip people with the tools and skills to better manage their health and wellbeing and improve quality of life' (Sussex Community NHS 2015).

²³ As a term it has also been widely criticised by doctors in terms of its applicability to mental health by the way courses are delivered and the style of delivery (Greenhalgh 2009).

construct individual identities as ‘consumers’, ‘patients’, or ‘survivors’. These identities are made possible through institutional practices (2006). Speed’s article offered a valuable insight into ‘bottom-up’ constructions of mental illness by proposing a different conception of agency, with services users able to not just be the passive objects of terms such as ‘recovery’, ‘self-management’, ‘consumer’ or ‘survivor’ (2006). This framing has both legal and social consequences, with McHale & Gale highlighting that users can ‘have at once both a position of relative power (because of their ability to exercise choice in their purchase of health services) and a position of embodied vulnerability (because of their need for social care)’, although both vary considerably depending on the type of condition and the socio-political context (2015, cited in Gale & McHale 2015: 377).

These critiques are all of relevance to this study in highlighting the political and social contestations shaping mental health today. The position of mindfulness as a specific intervention is now explored in terms of the changes in the provision of contemporary mental health, and the evolving position of complementary medicine alongside epistemological challenges to the dominance of mainstream psychiatry.

- **6. Mindfulness-based interventions**

- **6.1 Evidence and recent applications**

In the introduction I presented MBIs as a set of spiritually informed practice. Here I give more detail about their reception and use. To an extent here my review of the literature thus starts to answer my first research question.

Over the past two decades, research on MBIs has increased significantly for the treatment of both physical and mental conditions, in particular in the treatment of symptoms of anxiety, depression, and other stress-related illnesses (Baer 2006; Hoffman et al 2010). The present-centred non-judgmental awareness associated with mindfulness has been argued to help people develop new relationships with forms of emotional, intuitively-based behaviours of which they are often not aware (Lilley 2014). A more ‘evolved approach’ has also been claimed to result from engaging the prefrontal cortex to regulate the limbic system (the part of the brain behind knee jerk ‘fight or flight’ reactions) (Heaversedge & Halliwell 2010). Current research by Kuyken and colleagues at the Mood Disorders Centre in Exeter has been at the forefront of collaborative research into this area (2008, 2015). MBIs have also been gaining

increasing acceptance and legitimacy within the health service along with the use of spiritual care programmes (Koren & Purohit 2014) for health practitioners themselves (Shapiro et al 2007; Germer & Sigal 2012; Khoury et al 2013).

One of the key areas of recent expansion in MBIs has been in the fields of neuroscience and neuroplasticity²⁴. Increasing evidence is being generated of the potential of mindfulness practice to actively change the neuro-pathways in the brain, and links drawn between increased plasticity of brains and with the onset of forms of mental illness such as schizophrenia (Brown et al 2007; van der Valden & Roepstorff 2015). The term 'neurological reflexivity' (Farb et al 2010) has also raised awareness of how sustained meditation practice can be associated with increases in neurological activity and connectivity (Brewer et al 2011). Some studies have focused almost exclusively on mindfulness's attentional aspects (Brown et al 2007), but most follow Bishop et al (2004), who argued that mindfulness consists of both adopting a particular approach to one's inner experience, and the self-regulation of attention²⁵.

Regular publications such as US-based Mindfulness Research Monthly (MRM) have contributed towards the visibility and acceptance of MBIs in the public health domain (Black 2010). In terms of NICE endorsement mindfulness for chronic pain has been under revision in the NICE guidelines since 2009 but is included in Scottish guidelines: *Health Improvement Scotland* (Sign 2015), and has been cited as an increasingly popular self-management technique (Reiner et al 2013; Bawa et al 2015). As listed by Cullen (2011), many other MBIs which have also drawn from the original MBSR course include:

- Mindfulness-Based Childbirth and Parenting,
- SMART in Education/Mindfulness-Based Emotional Balance,
- Cool Minds™ (for adolescents),
- A Still Quiet Place (children of all ages),
- Mindfulness-Based Eating, Mindfulness-Based Relapse Prevention,
- Mindfulness-Based Elder Care,
- Mindfulness-Based Mental Fitness Training,

²⁴ See the Royal Society's recently launched 'Brain Waves' project investigating developments in neuroscience and the implications for society (Royal Society 2014).

²⁵ Self-regulation of attention requires an individual being able to both anchor their attention on what is occurring in that moment, as well as to switch this attention in awareness from one aspect of that experience to another (Bishop et al 2004).

- Mindfulness Based Art Therapy for Cancer Patients,
- Mindful Leadership™,
- Mindful Schools,
- Mindfulness without Borders,
- Trauma Sensitive MBSR for women with PTSD

many other programmes. Norway, Sweden, Holland, France, Ireland, Germany, South Africa, Switzerland, and Italy are among the countries with institutes and national associations of mindfulness teachers and trainings (ibid). A graduate programme in MBCT at Oxford University funded by the NHS has also been recently established.

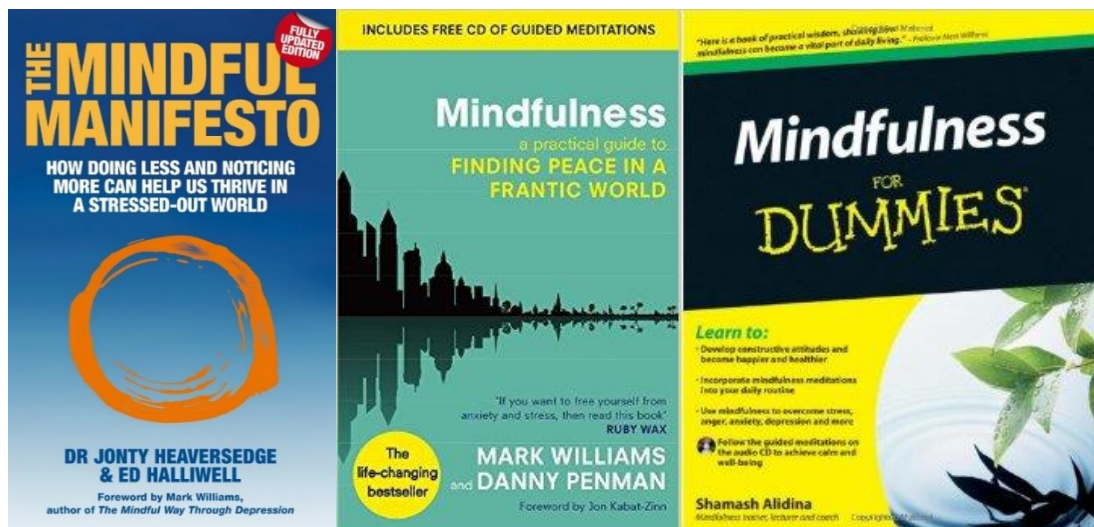
In terms of varied applications of MBIs, the current ‘.b’ Mindfulness in Schools Project (a nine lesson mindfulness courses for schools) has also been promoting the use of MBIs in education and exploring the ways in which it can be incorporated into curricula (Mindfulness in Schools 2015). Figure 1 below (SPFT photographer portfolio 2014), shows Willem Kuyken and Chris Cullen, co-founder of the Mindfulness in Schools Project, taken at the Sussex Mindfulness Conference 2014.



Figure 1: Willem Kuyken and Chris Cullen, co-founder of the Mindfulness in Schools Project (SPFT photographer portfolio 2014)

MBIs have been championed by particular individuals within mainstream biomedicine, psychiatry, politics, and popular culture as being an effective way to approach both physical and mental wellbeing. The integration of MBIs into the mainstream has been due to more than just the rise in popularity of CAM: other reasons include the dissatisfaction of both patients and clinicians with pharma-based solutions to common mental health problems (Teasdale et al 2000; Segal et al 2002); the promotion of MBIs by key opinion leaders (Flodgren et al 2011); and the beneficial embodied experiences cited by particular individuals (Heavershedge & Halliwell 2010).

Analysing the motivations of key stakeholders can help to reveal what might be at stake behind the different agendas at play. Claimants of the agenda also present the therapy and its evidence base in particular ways. In the media MBCT courses have been promoted through a series of strong public profiles held by a few people such as Mark Williams, the Director of the Oxford Mindfulness Centre, and Ed Halliwell and Jonty Heavershedge, who co-wrote *A Mindful Manifesto*, a book with widespread popular appeal (Heavershedge & Halliwell 2012). Halliwell also runs both private MBSR courses in Sussex and the online Mental Health Foundation course (Halliwell 2012). Figure 2 (2014) below illustrates this publication along with a range of the currently high profile mindfulness publications:



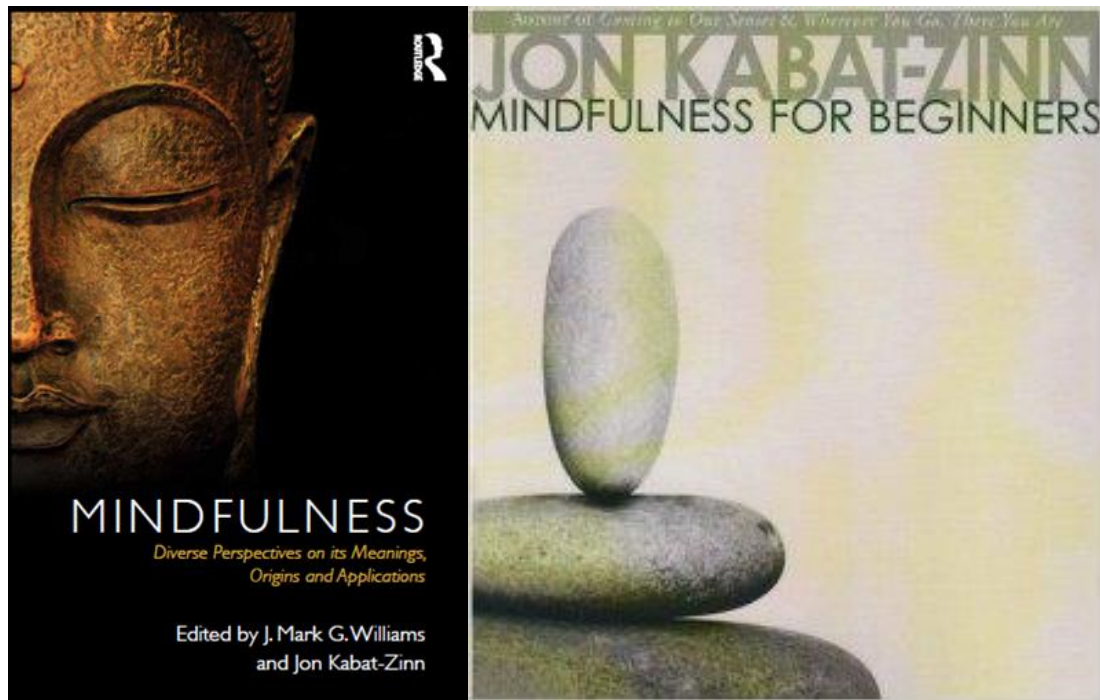
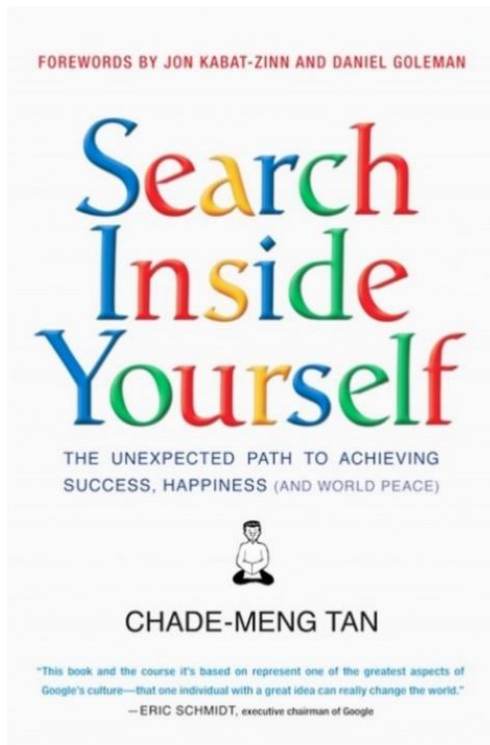


Figure 2: Mindfulness publication covers (Mindfulness publication front covers 2014)

Recently in the UK there has been increasing interest in the potential application of mindfulness within government. This is evidenced by the provision of mindfulness training being offered to MPs and Lords in Westminster, and Assembly Members in the National Assembly for Wales²⁶. The Mindfulness, Behaviour Change and Engagement in Public Policy (MBCEPP) programme was delivered to 15 members of the Welsh Government's civil service and sought to systematically combine mindfulness training with the insights of the Behaviour Change Agenda. Developers of this programme were examining the extent to which MBBCT could help to address questions of ethics, empowerment, and efficacy directed at behaviour change policies (Lilley et al 2014). An All Party Parliamentary Group (APPG) has also been established to study the potential benefits of bringing mindfulness into the policy arena. The Mindfulness APPG is supported by the *Mindfulness Initiative*, formed of a coalition of Oxford, Exeter and Bangor Universities whose aim is to promote a better understanding of mindfulness and its potential within public services (Lilley et al 2014). The APPG published an updated report in October 2015, with an emphasis on the implementation of MBIs within organisational case studies (The Mindfulness Initiative 2015).

²⁶ According to participants the practices had enhanced ways in which they understood human behaviour and its related principles. The programme demonstrated the potential impacts of MBBCT on long-term, complex behavioural patterns (Lilley et al 2014).



MBIs have also become an object of staff training for members of corporations and organisations such as Transport for London (TFL), as well as being adopted in the corporate sector, with Google (see Figure 3 below), EBay, Twitter and Facebook among the organisations promoting it among their employees (Stone 2014).

Figure 3: Front cover of 'Search Inside Yourself' publication (Mindfulness publication front covers 2014)

Integral to the adoption of MBIs in the corporate sector has been the use of technology for 'e-health' (Morrison et al 2012; Lupton 2012, 2014), online MBI provision and use of mobile phone applications²⁷ (Murero & Rice ed. 2006) as a form of digitised health promotion (see Mind Apps 2014, and Headspace 2015), '*the world's first gym membership for the mind*', where the initial taster comes free then users pay per month for different meditation activities). A hugely popular feature of mindfulness e-health in the UK are online courses run by the Mental Health Foundation (MHF). The screenshot in Figure 4 below shows the *Be Mindful Online* course homepage (Mental Health Foundation 2015):

²⁷ A highly popular download being the 'Mindfulness Bell', a 5 minute meditation that claims "Relax! Meditation is easy! Let the mindfulness bell do the work for you!", and features the sound of a bell aimed to facilitate meditation.

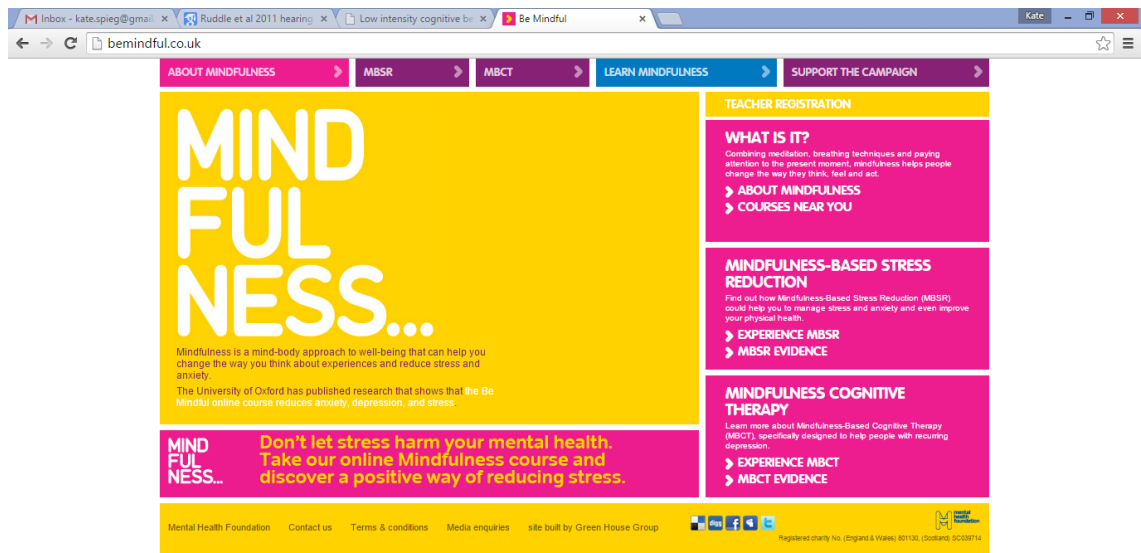


Figure 4: MHF online Mindfulness Course screenshot (Mental Health Foundation 2015)

Figure 5 below shows screenshots from the hugely popular Headspace App (Headspace 2015), the subject of recent RCT regarding its efficacy (Howells et al 2014);

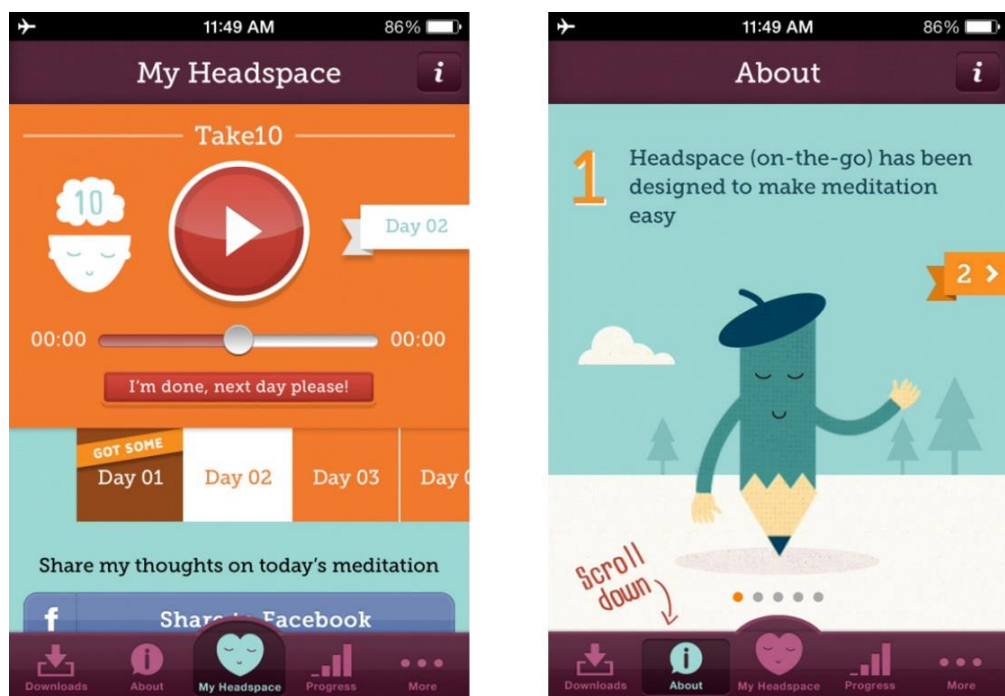


Figure 5: Screenshots from Headspace App (2015)

Whilst having self-empowering elements, the relationship between mindfulness and emotional regulation can also occupy the potentially problematic position of being used

as a management and governance tool to enable higher productivity levels in workplaces (Chaskalson 2011). These areas of application demonstrate the potential for therapeutic language to be combined with the ‘business speak’ used within both corporations and healthcare services. Critiques have been raised in the literature that although CAM is viewed by some as a counterpoint to conventional medicine, ‘the non-market ethos of holistic approaches can be illusory’ (McHale & Gale 2015, cited in Gale & McHale 2015: 378; see also Stone 2014). These critiques will be returned to in Chapter 6.

The increased visibility of MBIs within the health service and public eye, their championing by key individuals, and the rise in use of technology, are all contributing factors to be taken into account when examining the position of this intervention in relation to CAM. In terms of the relationship between the evolution of MBIs in the context of CAM, the literature of contemporary mental health and the rise of a plurality of providers and user voices can be drawn on to present an initial answer to my question; ‘*What is Mindfulness?*’.

A quite different literature of relevance has grappled with the meeting of epistemologies through sociological enquiry into the body, embodiment and emotions within Western psychiatry.

○ 6.2 Meeting of epistemologies in mental health

Insights from theories of emotions and embodiment can enrich the conceptual framework of the mindfulness agenda within mental health, and this chapter now considers this enquiry through the role that Buddhist-inspired MBIs play both *alongside* and *within* mainstream healthcare services.

In Buddhist philosophy from which mindfulness is drawn, the distinction between mind and body is not absolute, but is used instead as a tool to aid a holistic understanding of emotions. The body, feelings, perceptions and interpretations are accepted as facets of emotion (de Silva 2011), and articles such as; *Healing emotions: Conversations with the Dalai Lama on mindfulness, emotions, and health* (Goleman 2003) and *Buddhist and psychological perspectives on emotions and well-being* (Ekman et al 2005) are highly cited examples of this growing area of enquiry. Epstein’s work has been central in exploring Buddhist influences in mindfulness that may help break down restricting boundaries in clinical work, and developing psychological models derived from

contemplative traditions that can help to explain the complex mechanisms of change within MBIs (2008).

There have been centuries of attempts to find a common understanding between scientific and spiritual conceptions of reality. Scientists, philosophers, theologians and more recently sociologists (Epstein 2008; Mikulas 2011) have puzzled over this question, with disagreements over whether the epistemologies of the 'East' and 'West' are reconcilable, and whether mutual lessons may be applied to current academic debate surrounding contemporary healthcare. Literature on the relationship between Eastern philosophies and Western cognitive psychological frameworks remains specialist and is cited mainly within the journals of philosophy and theology. However there has been an increasing presence of these debates recently in the *Journal of Mental Health* as well as the *Mindfulness Journal*.

These issues are of central relevance to the question of what mindfulness *is* in terms of its position as a meeting ground for East and West, and space for the spiritual. Sociological arguments exploring Buddhist philosophy from which MBIs are drawn can be used to counter the traditional separation between religion and science. Grabovac et al argued that the set of beliefs and tradition of learning and rigour inherent to Buddhism are closely akin to cognitive psychology, despite being a system of practice with strong ethical and moral dimensions in the societies in which it originated (2011).

In relation to the roll-out and implementation of MBIs in Western contexts, key advocates of MBIs have been encouraging caution in its implementation (Shapiro et al 2006; Kabat-Zinn 2013).

'Enriching positivist Western psychological paradigms with a detailed and complex Buddhist phenomenology of the mind may require greater study and long-term direct practice of insight meditation than is currently common among psychologists and other scientists. Pursuit of such an approach would seem a necessary precondition for attempts to characterize and quantify mindfulness' (Grossman & Van Dam 2011: 221).

MBIs within Western medical contexts have allowed space in which to challenge traditional conceptions of the mind/body relationship, and its link to Buddhism, leading to new forms of reconciliation around knowledge and investigation, as well as notes of caution around place and practice.

○ 6.3 MBIs within complementary and alternative medicine

Mindfulness is framed as a complementary therapy by many organisations such as Rethink (2015), Macmillan (2015), and by many academic papers (van der Watt et al 2008; Greeson 2009²⁸). This positioning however does often not interrogate the distinction between complementary and alternative therapies in relation to the position of MBIs. MBIs are categorised in this study as a form of CAM in terms of an underlying philosophy of mind/body integrated health which both *complement* and may appear *alternative* to that of conventional medicine according to the evidence-based requirements of NICE, and increasing integration into the mainstream medical establishment (see Chapter 6). The ‘complementary’ position of forms of MBI endorsed by NICE (i.e. MBCT and mindfulness for chronic pain) can be contrasted with therapies commonly classed as ‘alternative’ such as homeopathy, which still occupies a marginal position within health care in terms of the clinical evidence (Saks 2003).

Further consideration is needed of how MBIs are classed in terms of ‘collusion with the dominance of biomedicine in the reproduction of binaries between different therapeutic approaches’²⁹ (Gale 2014: 807). Gale has argued that distinguishing between ‘integration as incorporation (with asymmetry of power favoring biomedicine and the orthodox professions) or as mutual transformation (with more symmetry and genuine complementarity) is not always acknowledged in the debates about integration’ (ibid: 811). The degree to which the use of MBIs within biomedicine has any tangible effect on the power structures of biomedicine remains a highly relevant question in the context of the increasing use of MBIs within the medical establishment.

In terms of having advocates within the NHS and biomedical establishment, it is unusual for a therapy such as MBCT to be endlessly adapted and tailored and retain its legitimacy (acupuncture being a possible exception) (Cant & Sharma 1999). Given credibility through inclusion in the NICE guidelines and adherence to EBM, MBIs may not occupy the same oppositional position as has been the case with other CAM therapies (ibid), but are in tune with the current emphasis on self-management, as well as having legitimacy based on its cost effectiveness (being a group rather than individual intervention; see Chapter 7).

28 Notably published in the Journal of Evidence-Based Complementary & Alternative Medicine (JEBCAM) (formerly Complementary Health Practice Review (Complementary Health Practice 2015).

29 Tendency towards the former can result in IM as a concept losing its efficacy.

The adoption of MBIs by the US and UK occurred alongside changing perceptions of the relationship between mental and physical health, and reactions to bio-reductionism in social and psychological explanations for mental ill health (Pilgrim & Rogers 2010; Williams 2006). MBIs can be said to represent an explicit link between CAM and talking cures through their attempt to bridge between the mind and the body.

Awareness of one's existential states is not unique to the focus of MBIs, but has a rich and longstanding tradition in psychoanalytic and phenomenological psychology (Giorgi 2009). This raises questions as to why this Buddhist-inspired intervention has seen such success. MBIs relate to the growth of what Rose termed 'therapeutic vocabularies' (1999), the popular appeal of which reflects interrelated trends already touched on in this chapter; the steady increase in consumer demand for alternative healing practices, and the huge growth in popular health information in the media (Kivits 2013, in Orton-Johnson & Prior (ed): 213-226). Rose's perspective on the appeal of therapy as a way to 'endure the loneliness of a culture without faith' may also contribute to explaining the secular appeal of MBIs (1998: 220). Elements of faddism have also been suggested, though when practiced properly Stone has argued that it is difficult to see anything faddish about regular meditative practice, as it is a strenuous and disciplined enterprise for at least a proportion of those who undertake it (2014).

Despite the evidence for the benefits of regular mindfulness practice, a number of questions have been raised both in terms of patterns of MBI use, and ways in which this intervention has been applied in secular, non-therapeutic contexts. First, concerns have been raised that mindfulness is being too quickly adopted as a panacea-like solution to a range of social problems (Furedi 2003). Second, long-term mindfulness practitioners and teachers have claimed that care needs to be taken to insure that as mindfulness is adapted and applied within new contexts, that its core messages and values are not forgotten (Lilley et al 2014). In integrating MBIs into a Western health service, arguments have been made that mindfulness needs to be embedded within a broader worldview (Kwee 2010), including how the practice relates to ethics, concentration, insight, social/cultural factors, and selfhood (Mikulas 2011). Grossman has also argued that many people who apply mindfulness in their organisations lack a broader understanding of its broader context, and similarly that many people who study and teach mindfulness in fact lack a sustained and embodied mindfulness practice (2010).

Take-up also remains largely restricted to a particular demographic of white middle-class women (Ernst 2000), which is also representative of wider take-up figures for many forms of CAM and indeed MBIs (as can be seen in the take-up column in Table 4 in Appendix 12) (ibid). MBIs as a particular form of CAM have also been situated within broader sociological discussions of medicalization.

▪ 6.3.1 Mindfulness and medicalization

A compelling argument has been made that CAM does not provide a complement or alternative to medical domination, but instead represents new forms of medical social control (Barker 2014). The principal promoters of medicalization in this sense are not physicians or the institution of medicine more broadly. Individuals instead routinely encounter ideas about health and illness that promote medicalization in discourses that circulate widely in the public, frequently disconnected from the institution of medicine (Furedi 2003; Rose 2006; Barker 2014).

In the article *Mindfulness meditation: Do-it-yourself medicalization of every moment*, US sociologist Kristin Barker made an effective argument for mindfulness representing changes in the nature of medicalization itself (2014):

‘On one hand, mindfulness decouples healing and curing, claiming to privilege the former. Because healing is a state of mind, it is framed as always within our reach, independent of the level of disease or the degree to which we are cured. On the other hand, healing and curing are not consistently decoupled and the claim to privilege the former belies a strong emphasis on the latter’ (Barker 2104: 173).

Barker argued that MBI course materials are not deliberately deceiving, but instead blur the lines between healing and curing, implying that individuals be capable of both. She goes on to argue that this conceptualisation of healing exposes a ‘troubling consequence of medicalization; namely, the tendency to define problems or their solutions as abstracted from their social context’ (see Zola 1972; Conrad 2007) (Barker 2014: 174). The tie between MBIs and medicalization according to Barker is that ‘the definition, cause, and treatment of disease as articulated by popular mindfulness resources expands the terrain of experiences and problems that are mediated by medical concepts’ (ibid: 168). The findings of this study suggested however that MBIs are not expanding what is treated as an illness or a disorder, but are attempting to treat the suffering universal to the human condition. This was suggested through the commonality of particular stated benefits of MBIs, and a lack of evidence from any

study participant of mindfulness adding an illness or problem to an individual's conception that had not existed previously.

Barker's article can be situated within a growing critical conversation about the position of MBIs within a sociology of medicine and health, in which it has also been claimed that contradictions within mindfulness confound its critique of the biomedical model (ibid), and that MBIs can be aligned with healthism or healthisation³⁰ (Crawford 1980; Williams 2006) both ideologically and in the extension of healthism's terrain.

'There is increasing recognition that effective health care requires engaging patients in looking after their own wellbeing. Much, if not all, illness is influenced by stress, mental attitude, and behaviour choices. If we are to lighten the load on overstretched health services ill-equipped to deal with chronic, stress-related conditions, we need new approaches that can help people manage their well-being. Increasingly, the focus in health care generally, and mental health care especially, is on strategies that can prevent illness occurring or re-occurring and promote health and well-being. Mindfulness courses are entirely in tune with this approach. While they can help people deal with illness, they are by nature a health promotion (and illness prevention) tool. They encourage people to be psychological masters of their own mind and body states, however well or ill they are' (Halliwell 2010: 53).

Halliwell's statement for the MHF above demonstrates effectively how MBIs can be seen as a health promotion strategy, one that allows individuals to make informed choices, and through mindfulness to have the opportunity to exercise self and bodily autonomy. Through the use of technology, and a reduced deference towards experts, medical expertise has become increasingly egalitarian in nature, with the 'expert patient' argued to have the capacity to manage their own disease, either individually or collectively (Tattersall 2002). At the end of the twentieth century, the 'sick man' (or woman) as discussed in Chapter 2 (Jewson 1976) could thus be said to have reappeared. However despite these challenges to biomedicine, earlier critiques of the health promotion and CAM agendas can also be extended to the 'mainstreaming' of the mindfulness agenda, with MBIs part of a move *back* to biomedicine.

Mindfulness is a highly interesting phenomenon to study in terms of previous areas of research on embodiment and emotions, though previous research has tended to show 'little regard for issues of social *praxis*, including the 'use' to which bodies are put in society and the learnt 'techniques' they draw upon in the conduct and negotiation of everyday life' (Williams & Bendelow 1998: 28). Voices from within the EBM paradigm

³⁰ Meaning the preoccupation with one's personal health; a goal thought to be reached through the living of particular life-styles, with or without therapeutic help (Crawford 1980).

have also highlighted ambiguities surrounding the definition and operation of the mechanisms of mindfulness in research on psychological therapies, and how the method of measurement can have an impact on clinical trial results (Petrik & Cronin 2014). Several empirical studies of MBIs have also been criticised methodologically, such as for the absence of control groups, randomisation or details of the randomisation, small sample size, and the frequent use of a waiting list as a comparative group (Chiesa & Serretti 2010). Other limitations cited have included the common absence of follow-up measures, reliance on self-reporting, and frequent differences across courses regarding total duration, homework, and the practices (ibid). This study attempted to take these critiques into account when examining the exponential growth in published studies in this area (see Chapter 4).

Having situated the growth of MBIs within critiques of medicalization, critiques of CAM, healthism, this chapter will conclude with a discussion of how the psychological literature is now describing MBIs and denoting their applications. A critical issue is which groups and conditions can benefit, helping flesh out the meaning of MBIs in the academic literature.

○ **6.4 Latest applications and limits of Mindfulness-based interventions**

Psychosis was thought of in the past as a biological condition out of the reach of psychological interventions. More contemporary research has shown that positive symptoms like hallucinations, delusions and voices are on a continuum with 'normality' and may be suited to adaptations of CBT found to have efficacy for the treatment of anxiety and depression³¹ (Kuipers et al 2006).

Mills's paper *'The Experience of Fragmentation in Psychosis: Can Mindfulness Help?'* described centering and grounding techniques that could be used to counter the sense of fragmentation common to people diagnosed with psychosis (2010, in Clarke 2010: pp.211-221). According to the cognitive model of psychotic disorders, vulnerability to psychosis comes from both biological factors and adverse factors like trauma, abuse and alienation (ibid). Central to cognitive approaches is that distress depends on how an individual appraises or makes sense of experiences, exploring the 'schemes' or

31 In terms of wider endorsement, CBT for psychosis (CBTp) was endorsed by NICE in 2009 (Berry & Hayward 2011), which gave some hope that the adaptation of this therapy to incorporate mindfulness may also be useful for this client group (Jackson in Clarke ed. 2010).

assumptions that lie behind a particular way of seeing the world (Chadwick & Birchwood 1996). Group CBT for voices starts with normalising voices, with focus on voice triggers and resulting thoughts or actions (e.g. Chadwick et al 2000; Davidson et al 2010). The hope in spending time testing habitual beliefs is to increase an individual's sense of control or power. These groups may also focus on coping strategies, relapse prevention, and self-esteem (Ruddle et al 2011).

As a stigmatised group, people who hear voice hearers can benefit from socializing with others with similar experiences, and hearing voices groups (HVGs) are commonly seen as an alternative to individual therapy (Ruddle et al 2011). Groups can act as a counterpoint to fragmentation (Mills 2010, in Clarke 2010), and provide a safe space for people to share experiences and strategies for coping, as well as the opportunity to consider alternative beliefs about these voices³² (Ruddle et al 2011). A key factor in this developing area of enquiry is that MBIs for the treatment of psychosis are aimed not at *lessening* psychotic experiences but at increasing coping mechanisms and distress caused by the voices (Bach et al 2012, *italics mine*). The focus is not on the content of the voices but on the relationship *with* them (ibid; Abba et al 2008), 'noticing internal experiences without trying to control them, as lessening the active attempts to control odd cognitions lowers susceptibility to them' (Bach et al 2006: 106).

The application of MBIs for the treatment of psychosis and distressing voices has been developing a significant body of support empirically (Bach et al 2012), with extensive research 'examining cognitive intrusions and their role in psychopathology' (Morrison 2001; Bach et al 2006). In Berry and Hayward's thematic analysis of CBT for psychosis, many of the study participants appeared to move towards accepting their experiences of psychosis, both in thought and behaviour (2011). Techniques applied in recent studies involving Mark Hayward, Director of Research for SPFT, and Paul Chadwick have also shown a reduction of the perception of the power of the voices (Berry & Hayward 2011; see also Fowler's work in Sussex on psychosis and early intervention (2013).

This chapter now review positions taken *against* the application of MBIs for psychosis. After the publication of *Accepting Voices* by Romme and Escher (1993) – a formative

32 Chadwick et al examined the impact of group-based CBT for drug resistant auditory hallucinations or voices (2000). No affective changes were evident in this study, though certain individuals showed significant spontaneous changes in behaviour, and measures also suggested that participants valued the groups and benefited from them (Ruddle 2011).

early discussion of this area of enquiry - Raymond Cochrane, professor of psychology, strongly critiqued the book in the BMJ as being 'potentially dangerous' and leading to collusions with delusions (Romme 1994). Johanson has also argued that 'mindfulness has a wide applicability' and a 'willingness to be introspective', but that 'those on the edges of psychosis do not have sufficient psychic structures in place to allow them to study themselves mindfully' (2011). For many people, psychotic experiences are unambiguously negative, with voices often shaming or attacking. Clients with a diagnosis of psychosis can often have multiple other difficulties including substance misuse (Bach 2006), and mindfulness practice may react with antipsychotic and other medication people may be taking. Bach et al's systematic review showed that a 'significant number of patients still do not respond to these interventions, and even those who do are by no means symptom free' (ibid: 97). There can also be negative sides to the increased self-understanding that MBCT is aiming for, and 'meditation has triggered some reported spiritual emergencies' (Lukoff 2010, cited in Clarke 2010: 213). In Berry and Hayward's study not all of the participants reported wholly positive consequences of this increase in understanding³³ (2011).

It is important to consider methodological weaknesses that undermine the reliability of data supporting mindfulness for distressing voices, past studies have been relatively few in number, with many of them uncontrolled and without the mechanisms of change clearly specified (Bach et al 2006, 2012). Barriers identified to implementation have included: 'a lack of staff time to consider appropriate referrals, pessimistic views of recovery of psychosis and a lack of skilled therapists able to work therapeutically' with particular service users (Waller et al 2013: 98). It has also been increasingly highlighted that despite the efficacy of talking therapies, people experiencing schizophrenia and other psychoses can still lack access to these therapies (Berry & Hayward 2008; Kuipers 2011).

- **7. Conclusions**

This chapter considered evolving debates around evidence-based medicine (EBM), and the economic imperative of NICE and the use of RCTs. The role of EBM in localised responses to innovation and clinical decision making was explored (Gyani et

33 This may be as true for participants of courses as for general members of the public for whom issues of difficulty may arise in the moments of meditation and reflection that are part of an MBCT course.

al 2014), as well as the contribution of the sociology of expectations, hope, and role of opinion leaders and champions in the management and diffusion of innovation. Sociological enquiry into the genealogy of psychiatry demonstrated its 'multiple nature: as a healing and scientific enterprise...a vast human experiment' (Newnes 1999, cited in Newnes in Newnes et al 1999: 2). Increasing critiques about the nature of this experiment have been raised from both within and external to psychiatry, which throughout the 20th century asserted its medical authority, though fundamental questions remain about its legitimacy (Bracken & Thomas 2001).

Literature on SU involvement in research has been an integral part of the campaign by the critical-, post-psychiatry and recovery movements to bring the social and historical context of lived experience to the fore (Pilgrim & Rogers 2005). Despite this involvement, an emphasis on VBM, and the growth of PPI however, further challenge is still needed to the traditions of clinical practice (Stewart et al 2011; Dallos 2011, cited in Rapley et al 2011). It is for this monitoring role that the critical- and post- psychiatry and recovery literature has often positioned itself.

The evolution of psychiatry and the development of a market of healthcare providers and plurality of therapeutic options has been illuminated through sociology's focus on the relationship between shifting policy priorities and the organisation and power distribution within public health and mental health. Discourses continue of the 'burden' of mental illness (Pilgrim & Rogers 2010), and Western societies continue to frame personal and social problems as medical in nature, and both self-management and CAM have been identified as both encouraging as well as resisting medicalization (Barker 2014). Attempts to clarify appropriate ways to research the rise in popularity of CAM have included the salience of contextual factors, as well as the embodied emotionality discussed in the previous chapter (Williams & Monaghan 2013). The evolution of MBIs was positioned within these debates as now being understood through the EBM lens, but also as a form of patient-led practice. The contribution of sociological enquiry into the meeting of epistemologies between Buddhism and Western cognitive psychological frameworks also evidences the development of holistic thinking. M4V was considered as an example of the latest application of this therapy to diverse populations.

CHAPTER 4. METHODOLOGICAL DISCUSSION

• 1. Introduction

Chapter 4 sets out how this study explored the theoretical and practical elements of mindfulness-based interventions (MBIs). I outline its main aims and the research process as it evolved from the initial research questions to the collaboration with the '*Mindfulness for Voices*' (M4V) randomized controlled trial, and practicalities of ethnography and participant observation, including data sampling, collection, analysis, and dissemination. I focus on the theoretical, practical, and ethical issues that arose and how these were addressed and managed. I critically reflect throughout on my position as a researcher, exploring how my own biography, identity, and values affected the direction and evolution of the study.

• 2. Epistemological and ontological stance

This study was not driven by a specific hypothesis, but rather by gaps in knowledge about the applicability of mindfulness to people experiencing psychosis, service user (SU) involvement in research, the practical implementation of MBIs, referral pathways to MBIs, localised uses of EBM and factors affecting variations in responses to evidence.

I hoped to gain an insight into the particular development trajectory and position of MBIs in an era of increasing medical pluralism and discourses of citizen and consumer choice in healthcare. To do this, I chose a combination of theoretical models to attempt to explore the variety of perspectives from different stakeholders, as well as open up difficulties encountered in the implementation of MBIs and the role of socio-economic inequalities in the take-up and ongoing practice of MBIs.

My aim in this study was for what Stenhouse termed 'illuminative evaluation', seeking 'not only judgement in the sense of 'verdicts', but ones which may provide a basis for future developmental work' (1975: 47). Part of this basis for future development relied on a 'polymorphous engagement' (Hannertz 2002), which Gusterson has argued will increasingly be used by researchers (1997). My interpretation of polymorphous engagement was taking the perspectives of key stakeholders of MBIs in Sussex as a basis for the direction and content of this study, collaborating with a wide range of interested individuals across a number of different settings using a variety of methods.

This approach coincided with my belief that the research study would ultimately be a product of the interaction between myself as a researcher and the participants who engaged in my study.

I was interested in gaining access to the experiences of attendees of mindfulness courses, course facilitators, health practitioners, clinicians, and policy-makers. Ingleby has warned of the dangers of cultivating the empirical at the expense of the conceptual in social science, highlighting that what matters 'are the principles which govern the acquisition and interpretation of 'findings', as much philosophically and scientifically' (2004: 24). Much research on the broad spectrum of complementary and alternative medicine (CAM) and integrative medicine (IM) has lacked both a theoretical framework and bridge between biomedicine and CAM theory and practice.

A focus on individual experience was also an important epistemological stance, though gaining an understanding of this experience was not a simple process. Language is 'culturally and sociologically constructed', affecting how individuals interpret, act and respond to the world around them (Theodosius 2008: 55). Feminist theorists have been key in investigating the authority of experience as epistemology (Nicholson 2013; Ryan-Flood & Gill ed. 2013), asking whether what study respondents say can be trusted to be an accurate or true reflection of their inner emotional life. Carrying out semi-structured interviews raised key ontological questions regarding reality and the self, whether knowledge is possible, and how to encompass meanings and subjective experience. Interviews do not give direct access to selfhood or the lived experience and subjectivity of the respondent, nor should be assumed to do so (Mauthner & Doucet 2003).

The language available to us determines how we are able to 'carve up' the world. This structural linguistic perspective (De Saussure 2011) can be contrasted with the attempt through embodied mindfulness to experience the world *beyond* this divisive function of language. Through efforts to communicate this experience however, the world of discourse is rejoined in a reliance on language. Rick Iedema has summarized the problematic aspects of analysing interview scripts for meaning by arguing that 'the field does not come as text' (2011: 1). Interview transcripts cannot bring into the frame the materialities of 'pre-discursive' emotions, energies, resistance to discourse and historical contexts of their production. Aspects of the internal structure of bodily consciousness will appear in the way we converse, but scrutiny can only be carried out at the external level, and this boundary to the sayable will exist in any interview. States

of mindfulness, and the evolving relationship between a person's mind and body through mindfulness practice, cannot be revealed through discursive constructions, and there is a need to analyse these constructions in the context of their occurrence, as a 'speech act' (Potter & Edwards 1991). This has not been possible within the limits of this project³⁴. Swartz argues that two levels of understanding are required on the part of a social science researcher; first of the embodiment of particular qualities of mindfulness, second the ability to communicate that understanding (see also Gergen on persons as '*multi-beings*'³⁵ 2008) (2012).

To examine the ontological and epistemological issues raised above, I aimed for a relational ontology which rejected the idea of a separate, self-sufficient, rational 'self', seeing people as 'interdependent rather than independent and as embedded in a complex web of intimate and larger social relations' (Mauthner & Doucet 2003: 423). Reflexivity was key for this relational ontology.

In terms of both lived experience and the language used to describe it to oneself and others, levels of psychological distress, well-being and mindfulness also cannot be treated as empirical or bounded entities or states of mental health. Difficulties in specifying psychological mechanisms of change is thus a key ontological and methodological issue. I explored potential issues with current definition of mindfulness and use of psychiatric scales, in agreement with Masse that the 'construction and validation (of scales) leads to the denaturalisation, objectification, and the encapsulation of the meaning of distress' (2000: 412). Despite being in agreement with Masse's argument, I also took the evidence generated by quantitative measurement scales as the basis for some of my arguments. Although I interrogated their meaning, there were certain fundamental conditions or states I took to be true. These scales included those used to evaluate mindfulness interventions; many of which are borrowed from psychology, such as self-compassion (Self-Compassion Scale; see Neff 2003), rumination (Ruminative Responses Sub-scale of the Response Styles Questionnaire; see Treynor et al 2003), dysfunctional attitudes (Dysfunctional Attitudes Scale; see Floyd et al 2004) and acceptance (Acceptance and Action Questionnaire; see Bond et al. 2011). Several mindfulness measures have also been developed

³⁴ Reasons for this included the time I had available for data collection and analysis.

³⁵ Gergen attempted to understand human action from a relational rather than individual perspective, as 'constituted within multiple relationships from which they emerge with multiple, incoherent, and often conflicting potentials' (2008: 335). This idea can be linked to therapeutic challenges in the context of mindfulness sessions; including pressures on the facilitator and the role of non-specific factors in the benefits.

specifically for the measurement and evaluation of MBIs based on self-reporting of trait-like constructs³⁶ (Van Dam et al 2009; Hick 2010; Germer et al ed. 2013).

I also could not separate my study from academic debates surrounding the legitimacy of psychiatric ‘scales’ of the ICD and DSM expansion debates set out in Chapter 3, through my subscription to the diagnoses given to participants on the M4V trial.

• 3. Case study approach

A consideration of the aims and objectives of a research study are of key importance in determining the research design and methods to be used (Yin 2013). I divided the stakeholder groups being interviewed into four ‘work packages’ (WPs) detailed below; both for pragmatic purposes and to allow differentiation between groups at the analysis stage (there of course being variations *within* the WPs).

- WP1: Mental health service user participants on the *Mindfulness for Voices* (M4V) RCT
- WP2: Participants on MBCT and hybrid MBCT/MBSR Sussex community courses
- WP3: Health service staff with a referral capacity, clinicians and GPs
- WP4: Mindfulness teachers, academics and policy makers

Ethnography involves the collection of multiple types of data in trying to capture the detail and complexities of a research site (Hammersley & Atkinson 2007) and context through which meanings are produced (Polgar & Thomas 2000). Yin argues a case study approach to be particularly useful in understanding how interventions exist within the ‘real life’ of policy and practice, and for understanding complex individual, social

36 These have included:

- Mindful Attention Awareness Scale (MAAS)
- Freiburg Mindfulness Inventory (FMI)
- Kentucky Inventory of Mindfulness Skills (KIMS)
- Cognitive and Affective Mindfulness Scale (CAMS)
- Mindfulness Questionnaire (MQ)
- Revised Cognitive and Affective Mindfulness Scale (CAMS-R)
- Philadelphia Mindfulness Scale (PHLMS)
- The Toronto Mindfulness Scale (TMS)
- Five Factor Mindfulness Questionnaire (FFMQ) (Van Dam et al 2009; Hick 2010; Germer et al 2013).

Baer et al called for researchers to include measures capturing the nature of the shift in relationship to experience that is the focus of mindfulness-based training (2008). These measures are increasingly included in large RCTs (e.g. Kuyken et al 2008, 2015).

and organisational entities (2013). As a case-study Sussex was not representative of other areas of the UK in either demographic terms, service provision, or in the practices or policies of the NHS Trust, and this affected the degree to which generalisations could be made from the data.

During the course of the study I became involved with in the mindfulness community in Sussex, and established collaborative links with members of the voluntary sector in Sussex and Sussex Partnership Foundation Trust (SPFT), including key members of the Research and Development team and the coordinator of Service User and Carer Involvement, Ruth Chandler. Spending time in the field allowed me to develop wider connections to those in work package 4, including John Kapp (a local social enterprise founder, mindfulness teacher, and vocal advocate of this form of therapy), Sarah Danily (the Director of Brighton & Hove MIND), staff at Rethink, members of staff at the Department of Primary Care and Public Health Sciences at Kings College London, the Head of RAND Europe, and Felicia Huppert (Professor of Psychology at the Well-Being Institute at Cambridge University and leading mindfulness consultant) to discuss my research and possible collaboration.

To provide contextual detail to the study, I carried out participant observation at health promotion strategy meetings at the SPFT and Local Authority. In the initial stages of the research I had also hoped to observe health promotion visits in different communities around Brighton & Hove, particularly in Whitehawk and Moulsecoomb, but this was not possible for both practical reasons and as the focus of the study evolved. I attended multiple conferences and training events run by the SPFT and national mindfulness organisations, and also attended two 8-week long MBCT courses run by voluntary organisations in Brighton, which gave me an embodied insight into the practical workings of the MBCT course content and homework practices. During these moments, at coffee and lunch breaks for example, I met many people and engaged in informal discussion, which also provided a source of data and added to my status as an ‘insider’.

- **4. Practicalities of collaboration**

Taking a collaborative approach required constructive and critical reflection. I already had a number of beliefs concerning the research questions being posed, including the efficacy of MBCT and its potential to increase levels of well-being across a potentially wider demographic, informed by my personal experience, the research literature and

intuition. In collecting the data for the study and in the initial stages of analysis I became aware of myself as a subjective and 'embodied' researcher situated within and aligned with certain institutions and contexts such as the University of Sussex, the Sussex Partnership NHS Foundation Trust (SPFT), and the Economic and Social Research Council (ESRC).

Despite the 'reflexive turn' explored earlier, reflexivity has not yet been fully integrated into data analysis methods and study design. Practicalities and methods of research in practice, and the data are often seen as neutral separate entities rather than being interdependent and interconnected (Oakley 2000). At the same time, there was also be a limit to how reflexive I could be, and how far I could understand the influence of the assumptions behind my study at the time of conducting it, given that, as in Mauthner & Doucet's case, 'these influences may only become apparent once we have left the research behind and moved on in our personal and academic lives' (2003: 414).

As Dickson-Swift et al have explored, researchers frequently gravitate towards research projects exploring aspects of their own experiences and subjectivity³⁷ (2008). This closeness to the research project, or shared experiences with research participants, can build rapport during interviews through a process of sharing and self-disclosure (ibid). My journey through the PhD began with a focus on behavioural economics (BE), an interest which then moved onto emotions as the basis for engagement with MBIs on a personal and institutional level as the research evolved (see research journal extracts in Appendix 2). This change in focus demonstrated both the dynamic and changing nature of research, and the impact of my collaboration with SPFT.

This investment with SPFT enabled involvement with the M4V RCT, and as will be explored further below, there was a lack of clarity as to what kinds of knowledge were expected as a result of this involvement. This involvement also enabled the study being included on the NIHR portfolio. Because of this inclusion I had support in recruiting to the online survey from the R&D department at SPFT, and any GP completing the survey were also recompensed for their time.

Knowledge is contextually situated and co-produced between the researcher and participants, and my voice as a researcher and collaborator was a part of the overall

³⁷ Such as the way my own previous interest in Buddhism, mindfulness, and preventative health therapies influenced the choice of study.

analysis. I was conscious of my position on the periphery of the RCT whilst also being granted access to trial participants, and met regularly with my supervisors to discuss the ongoing research process, and kept in close contact with the LEAP, as well as the M4V clinical team³⁸. I used these reflexive considerations as a form of data on the collaboration with SPFT as well as the experience of mindfulness and the relational nature of working with staff working within the Trust.

The value of qualitative research alongside or as part of randomised controlled trials (RCTs) has become more accepted and applied in order to understand both the acceptability and feasibility of health interventions, or to improve the functioning of trials (Cooper et al 2014). An interactive relationship between qualitative research and RCTs is increasingly both recognised and sought, and the Medical Research Council (MRC) now acknowledges the contribution of qualitative data (Donovan et al 2002; Lewin 2009).

I recognised the potential benefits of the willingness of SPFT to collaborate with my study, and in return for access hoped to add value to and increase the impact of the aims and concerns of the Trust through involvement with the M4V trial. My experience of involvement in with the M4V RCT and how questions asked of the data kept changing, resonated with Strathern's statement on the research process; that 'at each juncture something more is generated than the answer requires' (2004, cited in Will & Moreira 2010: 154). I met with various stakeholders in Sussex over a 6-month period as part of the development of the research questions and topic guides, the content of which was led by these consultations, as well as my own research interests. I met with the Director of R&D for SPFT, who discussed M4V as a trial just being started that the Trust was involved in. This RCT was testing the primary hypothesis that personal-based cognitive therapy incorporating mindfulness, in comparison with treatment as usual will lead to significant reductions in distress and disturbance in response to hearing voices.

During the initial meetings with SPFT, M4V was raised as an object of shared concern, and MBCT for people with psychosis who experience distressing voices, and my involvement with the M4V trial became part of my study after this meeting. I then developed relationships with some members of the M4V clinical team, Ruth Chandler and members of the SMC. Through an ongoing relationship with Ruth Chandler I then

³⁸ I also had access to a number of social scientists and ethicists with whom to discuss my findings and help to compensate for researcher bias.

became involved in analysing a sub-section of my own data – interviews with a sample of participants on M4V - for use alongside the RCT.

As Chapters 2 and 3 discussed, the emphasis on holistic wellbeing and critiques of biomedicine created a space of diagnostic fluidity in which treatments for one condition could be tried for another. In terms of the application of mindfulness for a serious mental illness (SMI) such as psychosis, M4V in many ways represented a shift away from the pharma-focused treatments of biomedicine, one that the era of the rise of talking therapies had moved part-way to collapsing. Through the collaboration with SPFT this study started to coalesce with and become a part of this story.

My study was prospective and exploratory, amassing data to take to a next prospective stage, and I was not asking questions that an RCT could answer. I wanted a relationship with the RCT as a critical partner/friend, and had an interest in how people made sense of their experience of both the MBCT intervention and experience of the trial. Meanwhile the SPFT were interested in making sure that people received what they tried to deliver. This provides an additional difference of qualitative research to the quantitative data traditionally used by RCTs. The clarity of communication between myself and the members of the SPFT R&D team about their expectations of my involvement could have been improved, and as a result I was not clear over precisely what their aims and expectations were regarding my involvement. From the perspective of the SPFT Research and Development Team, benefits from collaborating with me may have been support in evidencing the qualitative impacts of MBCT on their demographic of focus, as well as continuing the positive working relationship between the Trust and the University of Sussex as research partners.

Figures 6 and 7 below evidence my embeddedness within the Trust; at the 2013 SPFT Research and Development Conference in front of my poster, and at the 2013 SMC Mindfulness Conference.



Figure 6: Author at 2013 SPFT Research and Development Conference (SPFT photographer)



Figure 7: Author at 2013 SPFT Research and Development Conference (SPFT photographer)

This study sought to bring to the fore users' views of the M4V RCT, and collaborations with service users involved in research in SPFT were integral. Throughout the study I sought advice from and worked alongside Ruth Chandler, the Service User Involvement Manager for SPFT. Ruth Chandler's experience and input was invaluable in re-drafting the topic guide, and getting data on the outcomes that are valued by the participants. This meant the submission of a second major ethics amendment submitted to the South East Coast and Kent REC, delaying the start of this group of interviews and meaning that the aimed for 6-month follow-up period following participants completion of the MBCT course did not happen. This had a likely effect on

the validity of the data in terms of participants' memory of the course.

I also attended meetings of the SPFT Lived Experience Advisory Panel (LEAP) for the M4V study, sending the initial research outline and study documents to the LEAP as well as the Mental Health Research Network (MHRN) (Sussex Partnership Lived Experience Advisory Panel 2014) for feedback. Input from the non-clinical side of the Trust was invaluable in shaping the direction of my research, in particular the focus on service user involvement theories. I intended to carry out the interviews of participants in the M4V trial (WP1) alongside peer researchers with lived experience who have been trained by Ruth Chandler but these researchers were not trained to a level at which they felt able to carry this out in time. This limited the potential data that could have been gathered on possible differing responses from participants according to the interviewer.

Interviewees across all participant groups (though less so in the M4V trial group) seemed to not want their own subjective experience of mindfulness to be extrapolated from or generalised. Reasons given were either that participants did not '*know what other people feel about it*' (Community MBI participant Yvonne), or had not had enough exposure to or of experience of the therapy to assess the popularity of MBCT. Admissions of personal bias and disclaimers put on opinions depending on whether they come from within the NHS or not were also common, or saying they '*just feel like a bit of a fraud... 'cause I'm not an expert on mindfulness, at all*'. (SPFT Manager Kath) or that '*whatever I might think personally would not be based on knowing, anything objective if you see what I mean*' (NHS Manager Sue). A reluctance to state one's opinion without a disclaimer however is not unique to discussions of mindfulness, but is also culturally pertinent in a context in which discussions of bodily experience is not common or encouraged (Lakoff & Johnson 1999).

The specifics of the methodological approach taken will now be justified in more detail.

- **5. Methods**

- **5.1 Triangulation**

Not to be confused with mixed methods research (MMR) – commonly thought of as a third major research paradigm alongside qualitative and quantitative (Johnson et al 2007) - triangulation is the 'use of different methods and sources to check the integrity

of, or extend, inferences drawn from the data' (Richie & Lewis 2003: 43). Denzin (2012) identified four types of triangulation: (a) method, (b) investigator, (c) theory, and (d) data source (Carter et al 2014). I used all four types in this study, with (b) employed through the qualitative study of the M4V trial.

Qualitative research commonly serves the function of detailing participant experience, rather than to inform or address professional practice or beliefs. Relating to public health, Green and Britten have argued that the qualitative research findings can also 'provide rigorous accounts of treatment regimens in everyday contexts', broadening the scope of evidence-based medicine (EBM) by addressing 'research questions that are different from those considered by clinical epidemiology' (1998: 1231). The theoretical focus of this study on both the embodied experience of mindfulness practice, and the implementation of evidence within a particular healthcare organisation, reinforces these dual purposes of qualitative research.

Qualitative research methods are characterised by a circular process where ideas from each stage of data collection informs the next, and the data collection, analysis and 'writing up' stages can be blurred (Gifford 1996). In keeping with this, each stage of this study has been informed and guided by knowledge gained through the research process. This inductive approach works well with ethnographic methods because it embraces the complexity and openness of the social world.

The 'use of multiple, integrated approaches is particularly useful in the evaluation of the effects of complex healthcare interventions' as these involve social or behavioural processes that are difficult to explore or capture using quantitative methods alone' (Lewin et al 2009: 1). I tried to remain alert to these tensions, taking an exploratory approach to the research rather than entering the debate of qualitative versus quantitative, or claiming my study to be truly MMR.

Will and Moreira have suggested that qualitative research and ethnography has something particular to contribute 'to understanding the connections, networks, organisations and institutions that are deployed in the production and evaluation of trial evidence' (2010: 157), contributing to recognising and integrating processes of involvement in the widest sense (ibid). The study aimed to measure some of the processes behind people's decision to take part in MBIs, and the particular outcomes from this intervention. I hoped that quantitative mapping of service provision and population demographic - combined with an inductive qualitative approach - would

allow the gathering of information and the development of theory to explore the underlying processes taking place, and allow the study of the complexity of the human experience without manipulation of the research setting.

○ 5.2 Recruitment and sampling

The use of an appropriate sampling strategy to answer the research questions posed added to the rigour of the study. Both recruitment and access to participant details required careful negotiation which differed between the work packages. Gatekeepers were invaluable in each WP in allowing the recruitment process, and were *themselves* data on the settings I wanted to study (Silverman 2011).

Table 1: Study participant numbers, recruitment method, sample size and demographic

Work Package	Recruitment Method	Sample Size	Demographic
WP1 Interviews: M4V RCT participants	Initial approach to potential participants from M4V had already been made by the research assistant for the study. Then did direct recruitment for my study through a letter disseminated via the M4V research team, and follow-up phone calls.	8 out of population of 144	3 Male, 5 Female. All White British.
WP2 Interviews: participants on MBCT course being run in the community in Sussex	Visited and attend mindfulness groups in Sussex, leaving my contact details and information about the study at the venue and with the course leader. Used contacts made through in-house provision of mindfulness groups by SPFT and the associated contacts. Having established links with	8	2 Male, 6 Female. 6 White British, 2 White - Irish

	mindfulness teachers and centres that ran mindfulness or MBCT courses during my ethnographic fieldwork meetings across Sussex in the initial stage of the study, made contact and met with mindfulness teachers to disseminate leaflets and emails to course participants.		
WP3 Interviews: Stakeholders involved in mindfulness courses: GPs, other clinicians and health professionals	Contacted GPs via the SPFT Mental Health Research Network, who were supporting my project in terms of disseminating the online survey and reimbursing GPs for the time taken to complete it. Also approached clinicians directly through the M4V research team.	14	5 Male, 9 Female. 12 White British, 2 Other White background
WP3 Online survey: Relevant clinicians within SPFT	Disseminated through SPFT Research & Development Team and Research Network.	203 out of a population of 3,390 staff in SPFT	GPs: 3 Male, 5 Female. 6 White British, 1 Asian or Asian British – Pakistani, 1 Asian or Asian British – Indian Clinicians: 141 Female, 54 Male. 1 Asian or Asian British - Indian 1 Black British 2 Black or Black British - African 1 Black or Black

			1 British - Caribbean 1 Chinese 1 Egyptian 1 Mixed - White and Asian 2 Mixed - White and Black African 2 Other Asian background 19 Other white background 3 Other White-British 160 White British
WP4 Interviews: Relevant academics, policy makers and mindfulness course facilitators	Followed-up on initial contact already made in the fieldwork with potential participants in LEAP, mindfulness teaching, academia and policy.	9	4 Male, 5 Female. All White British.
WP4 Participant Observation: SPFT meetings, MBCT courses in Brighton	Identification of MBCT courses and meetings through fieldwork research and snowball sampling.	38 hours spent in observation	

My research questions were concerned with varied experiences of MBIs, and in accordance with this and my epistemological stance I decided to use a purposive sampling strategy once I had chosen the different stakeholder groups (Mason 2002).

The determination of sample size in qualitative research can be influenced pragmatically in terms of how many subjects can be researched and evaluated in the

time frame allowed, and also when data-saturation is reached (a point is where a researcher feels that no further new issues are emerging from the data). Purposive sampling means that the total sample size in qualitative research interviews is often not known until the research is completed (Hansen 2006; Bryman 2012). This approach can be 'ad-hoc and unsystematic' (Mason 2002) and I approached this difficulty by choosing a number of informants who I thought would allow access to sufficient data to address the research questions I had established, allow the development and testing and development of theoretical perspectives, and be dynamic and ongoing.

In-depth investigation of the data places emphasis on the quality of the information generated rather than the quantity. Sample size in qualitative research is typically small and in part reflects the complexity and volume of the data as well as its association with theory and hypothesis generation. Qualitative research uses non-probability sampling without the aim of achieving a statistically representative sample or using statistics to infer causation. As a consequence, there is no formal sample size calculation when undertaking qualitative research such as this. I remained open for the need to interview more participants within the timeframe of the year of data collection, and an adequate range of stakeholder experience, and believed sufficient data was gathered for the purposes of this study.

During this process there was a lack of fit with the original ethics application submitted as the Integrated Research Application System³⁹ (IRAS) form had to be submitted very early in the study before data collection had started (see Appendix 1 for the Research passport that was needed in order to access participants). This resulted in the need for several submissions of changes to the committee during the course of the research, the approval for which was needed in order to continue, meaning that recruitment took place later than originally planned. My experience of the extensive period of time it took me to get ethical permission through the NHS for this study taught me to not to take either access to participants or a strict fieldwork timeframe for granted.

○ 5.3 Data collection

The flexibility of research design and sampling strategies in qualitative research allows the focus of research to change as the study progresses. This flexibility may increase the influence of ontological and epistemological assumptions, but also allow for the

39 The standard form of ethical review now used in NHS-based research.

accounting for participant perspectives (Whitley & Crawford 2005).

In order to explore my position as a researcher, field notes were made immediately after each interview, and I kept a reflexive journal throughout the study in order to audit my own feelings and attitudes. Journal records and reflections documented my journey as a researcher from having an outsider to a 'quasi-insider' status (Emerson et al 2001). Appendix 2 shows two extracts from early and mid-stages of the study, the first illustrating clarification of my thoughts following the first year PhD peer presentation session, and second extract illustrating the collaborative process. The research journal extracts also illustrate some of the uncertainty and organisational difficulties around waiting for ethical clearance and submitting amendments. I drew from and acknowledged my own embodied experiences of attending two 8-week MBCT courses during the research process. I was in agreement with the view that researchers should be 'unafraid to draw on their own experiences when analyzing materials because they realise that these become the foundations for making comparisons and discovering properties and dimensions' (Corbin & Strauss 1998: 5; Seidel & Urquhart 2013). This process increased my familiarity with the data (Fairclough 2013). The benefits of this approach lay in observing my emotions as the research progressed, and knowledge obtained from closely observing my feelings in relation to others (Flam & Kleres ed. 2015), as well as assumptions I held early in the study such as the efficacy of behavioural economics as applied to MBIs.

○ **5.4 Semi-structured interviews**

My epistemological stance led me to consider that qualitative semi-structured interviews and an online survey inviting free text responses would allow access to values, norms and meanings within the Sussex context and population being explored (Silverman 2011). The interview data collected was a product of social interaction between myself as a researcher and my participants (Mason 2002). The stories told by participants were also a product of the interview and their telling facilitated by the skills I used as an interviewer (Nunkoosing 2005). The information provided may thus be 'only one facet of the multiple aspects of the 'truth' (Grbich 1999). The validity of the interview as a research tool is supported by the argument that all narratives that the participant chooses to share are important in contributing to the understanding of their experience (Nunkoosing 2005). The emotions and experiences that participants shared with me maintained my belief that the interview format provided the opportunity access individuals' beliefs and experiences of perceived reality.

The first part of the interview schedule adopted an open-ended approach, allowing the participant to talk about their experience of mindfulness in their own way. This took the form of: *'Can you tell me about your awareness and impressions of mindfulness?'*, and *'What have you been up to since the end of the course?'* to get an impression of the participants' lifestyles and ways they spent their time. I attempted to avoid directive questions or assume any additional knowledge on the part of the participant, and did my utmost to ensure that I did not introduce new or unsought for information. To achieve these aims it may have been more effective to have un-structured questions around previously identified themes, which may have allowed respondents to guide the direction of the questions more. In hindsight, at times as an interviewer I was too concerned with keeping to the pre-determined structure and content of the topic guide, though I had chosen semi-structured questions in the hope to obtain data on a broad thematic range.

For those who had attended an MBI, the second part of the interview allowed for further exploration of the participants' experiences of mindfulness courses, their views on the evaluation they completed, the follow-up support they received. The concluding part of the interview returned to participants' views of mindfulness as a therapy, and focused on their views on the awareness and popularity of mindfulness, its current implementation in the health service, and for the treatment of psychosis.

All participants were interviewed once. Participants in all WPs were given a minimum of 24 hours to study the Participant Information Sheet (PIS) and Consent form before meeting for interview (see Appendix 3 for an example of the consent form for M4V participant interviews). Prior to the interview starting formally, the participant had the chance to ask any questions and give consent again. The actual length of the interview was determined by the participant, but I was sensitive to possible fatigue or whether a participant was feeling tired or wants to finish the interview early (see further discussion on ethics below). Most interviews lasted between 25 and 80 minutes. Following the interview, there was sometimes a need to check back with interviewees should anything be unclear, and permission to do so was requested at the end of the interview. Final contact was made with participants when a summary of the research was ready, having consulted with the LEAP to ensure that the research findings were presented in a way understandable to the lay population.

The timing of the interviews also had an impact in terms of gaining data on topics that

became the focus of my research in the later stages of the project, as the topic guide was adapted as each interview was carried out in response to the concerns and interests of the participants.

○ 5.5 Online survey

The survey was piloted on four members of SPFT staff first, along with helpful input from the R&D team at SPFT, and was revised following comments (see Appendix 4 for questions included in their online format) (Bryman 2012). It was then disseminated to members of staff within the Trust with a referral capacity to mental health services, with the assistance of the R&D department of SPFT. A total of 203 staff (6% of the total staff of the Trust) completed the online survey over a 6 month period, and were given prompts for completion by the R&D department. The local Mental Health Research Network (MHRN) in Sussex assisted in both accessing the GP sample, and reimbursing individual participants for the time taken to complete the survey. The survey was not sent to stakeholders in other WPs as it was tailored to obtain specific detail on referral patterns and clinical practice on a larger cohort than it was possible to interview and access. Clinical staff may also have been more willing to complete an anonymous online survey than take part in a more intimate interview, meaning that I got a higher response rate from that population within SPFT.

Respondents to the survey had the following roles: Primary Care, Community substance misuse worker, Community mental health nurse (CMHN), community psychiatric nurse (CPN), clinical psychologists, psychiatrist, Approved Mental Health worker, CBT therapists, GPs, and those working in a health centre, for *Health in Mind*, Assessment Treatment Centre, Recovery College, Learning Disabilities, Child & Adult Mental Health Services (CAMHS) and Secondary Care⁴⁰. CMHTs were the biggest category of respondents at 54%⁴¹. In terms of the age range of respondents 65 (32%) were in the 40-49 age bracket, with a close amount in the 30-39 and 50-59 age range (27%). These figures are very similar to the ages of SPFT staff, indicating this data to be broadly representative.

Feedback from survey participants included comments that the questionnaire was orientated to adult mental health services as opposed to staff working in Children &

40 Not all of these roles and settings were mutually exclusive.

41 The diversity of possible roles within these teams should also be acknowledged, and the corresponding effect on the validity of the data.

Adolescent Mental Health services (CAMHS), the survey then not being of direct relevance to their area of work. Other feedback included that the questions assumed that the only way of learning mindfulness is on a 'mindfulness course' and that was a one-off learning activity; this respondent had learned mindfulness in a Buddhist context and felt it to be an ongoing learning process. Because of the particular programme used to generate the survey⁴², it was only possible to select one option to the multiple choice questions, which many respondents commented on in their feedback. This affected the validity of the data generated.

On reflection the survey should also have also asked about the importance of the ICD, because this is the classification system mostly used in the UK rather than the DSM in the US. Answers to this question may still have been revealing in terms of the impact of debates on this side of the Atlantic around the DSM-V. MBIs are not included in the DSM or ICD, but the data collected from these survey questions may still be of relevance in terms of where clinicians turn to for evidence-based guidance.

- **6. Data analysis**

- **6.1 Qualitative analysis**

It is now widely recognised 'that the interpretation of data is a reflexive exercise through which meanings are made rather than found' (Fielding & Fielding 1986: 32 in Silverman 2011: 357). Researchers also play a role in the analytic process, bringing preconceived ideas, power relations and assumptions to the process.

The purpose of qualitative data analysis is to summarise and organise the data a way that allows research hypotheses to be tested or the research question answered (Avis 2005). The approach to analysing qualitative data is associated with the epistemological and methodological position of the research study; with this itself linked with the research question and aims (Green et al 2007). Reflecting the emergent and iterative nature of many qualitative studies I wanted to use an analytical process that was flexible. Thematic analysis (TA) is a popular means of analysing, and reporting patterns identified both within and across data sets (Boyatzis 1998).

⁴² 'Google Survey' was used because it was free and initially appeared to allow the flexibility needed. With hindsight, paying for the use of an alternative program such as 'Survey Monkey' may have been a better option as it allows the selecting of more than one option.

TA can be used within both essentialist and constructionist paradigms, and a central benefit of this approach is its flexibility; allowing its use over all of the WPs for an initial exploration of key emerging themes. I incorporated thematic analysis taking a constructionist perspective, where experience and meaning are seen as socially produced and reproduced, rather as inherent (Burr 1998). This is opposed to an essentialist/realist approach, where meaning and experience are seen in terms of a simple and mainly unidirectional relationship (Widdicombe & Wooffitt 1995). The exact form and products of thematic analysis vary (Braun & Clarke 2006), and this flexibility and openness has been linked with the existence of a degree of ambiguity (Corbin & Strauss 1998).

I wanted to be clear about how I went about analysing my data and the assumptions that informed the analysis, so that the study could be evaluated and compared with other topics on similar areas. Attride-Stirling et al highlighted the lack of clarity and detail that often exists in reporting the method of analysis, with claims of themes 'emerging' or being 'discovered' in the data (2001). Generally, the move from concept to concrete data collection and analysis involves a significant level of simplification (and the influence of possible assumptions both ontological and epistemological). This simplification 'entails re-defining a concept to include a more limited number of defining dimensions' (Goertz & Mahoney 2012: 208). From a qualitative perspective, the key issue remained tackling the meaning of the concept being studied (ibid), and I attempted to avoid this simplification process by trying to investigate participant perspectives through open-ended questions in the topic guide. Supporting quotes were selected from the original sample that I felt represented the range and depth of the varied views expressed by the participants.

I tried to take an inductive approach in which the themes pulled out may not have resembled the questions asked of the study participants (Boyatzis 1998; Braun & Clarke 2006). I thus used a data-driven process of coding that did not fit into a pre-existing frame or preconception, even though I structured my topic guides in a particular way in order to try to get data relating to my research questions. This approach is in contrast to identifying themes deductively, providing a detailed analysis of a particular part of the data-set driven by my own theoretical interests (Braun & Clarke 2006). I needed to acknowledge however that even with an inductive approach it was not possible to separate myself from my epistemological and theoretical preconceptions. What I wanted to avoid was simply mapping my research questions

onto the data set as the codes, and as far as possible to strike a balance between demarcating my use of this analysis clearly.

Expert opinion (Bryman 2004; Hansen 2006) advocates coding as soon as possible and encourages the transcribing of interviews by the researcher. This increases familiarity and expands the ability to make connections between different aspects of the data (Hansen 2006). Analysis of the transcripts verbatim was a lengthy process, begun during data collection, and was one that did not follow clearly defined stages. These components did not occur independently or in a linear way, and incorporated critical reflection to ensure that all data are explored and interpretations were generated.

As each interview was carried out, the data was transferred to NVivo, a qualitative data analysis software package. Computer assisted qualitative data analysis software (CAQDAS) has been viewed as aiding the search for an accurate overview of the data as well as a transparent audit of the data analysis process – a process which can be absent in qualitative research accounts (Welsh 2002; Bazeley & Jackson ed. 2013). Using this program codes were organised hierarchically into ‘coding trees’ to categorise and sub-categorise the emergent concepts according to their relationship to one another (see Appendix 5 for the coding structure using NVivo).

The codes generated were not predefined or definitive and faced continual refinement, analysis and critical reflection to check their validity. The codes or ‘labels’ attached to the data highlight points and areas of interest⁴³ (Grbich 1999; Bryman 2004; Hansen 2006). The use of coding trees added a further dimension to the analysis (through the use of sub-code under different ‘parent codes’) to explore how particular experiences or instances were talked about in the context of different topics (Bazeley 2007). This facilitated the identification of conceptual relationships both within and between codes⁴⁴. The audio interviews were checked against transcripts for accuracy, and the transcripts were sent back to respondents, who were asked in an open way for ‘any thoughts or comments’ about their interview. This question was kept deliberately open to allow the possibility of getting further data beyond their comments on typing errors.

43 These might reflect the words or language that participants use, descriptions of events that occurred or decisions about sampling that might be needed.

44 The creation of categories was concerned with an attempt to link codes and highlight relationships between them whilst theory generation attempted to present higher level evidence for the findings, offering interpretation rather than mere description.

Throughout this process I critically reflected on how data, evidence, beliefs and intuition might be interwoven. It was my belief that qualitative data could be subject to hypothesis testing and generation, and thus supported a strategy of analytic induction (Bryman 2004). Analytic induction and iterative thematic analysis both advocate a cyclical process of data collection and analysis: data is collected, subject to analysis, and then this analysis is utilised in the return to the field to guide further data collection (ibid; Hansen 2006; Silverman 2011). Analysis is a messy process and codes can be applied and themes emerge unconstrained. However, in the formation of chapters, structure is introduced which impacts on the framing of analysis.

Framework Analysis (FA) was chosen jointly with myself and Ruth Chandler as the method to analyse the M4V interview data. This is an analytic method which has become increasingly popular within health research for the management and analysis of qualitative data. Thematic analysis was used on all the qualitative sections of the survey as well as the interviews, and framework analysis (FA) used solely on the WP1 M4V interviews with which I was collaborating with Ruth Chandler.

A part of the complexity of my collaboration with the SPFT lay in using FA *as well as* TA on different parts of the data. The fact that FA is clear and staged makes it an apt method for interdisciplinary projects and for the analysis of interview data, with the need to generate themes by comparing *between* and *within* cases (Gale et al 2013). Similar to TA, in FA, interview transcripts are coded and organised into categories developed by the team of researchers involved in analysis, and is itself a form of thematic analysis. The difference between TA and FA lies in the use of a specific matrix for coding the data comprised of rows (cases), columns (codes) and 'cells' of data. This matrix provides a structure into which the data can be reduced for analysis in a systematic way (ibid).

During analysis, codes were grouped individually into clusters around interrelated ideas or concepts. Developing categories was a way to begin the abstraction of the data that was then developed into charts for the Framework matrix. This index was then tested individually in another thorough line-by-line re-reading of the interview transcripts. Further analysis of the data then took place using the agreed upon frame, not using NVivo as this program does not allow the FA charting process. This framework created a new structure for the data (away from complete participant accounts) that was helpful to support answering the research questions (see Appendix 6 for example of the tables used).

Ensuring transparency of the analytic process was vital, and this study took an inductive approach that Gale et al argued allows 'for the unexpected, and permits more socially-located responses' (2013: 3). As Gale et al suggested, researchers were 'not too attached to certainty, but remained flexible and adaptive to attempt to embrace and explain the complexity of real social life' (ibid: 4).

Summarising the data during the charting process, as well as being practical, meant that all members of the research team could engage with the data during the analysis without the necessity for all of them to read all the study transcripts or be involved in the more technical parts of analysis. This also left an audit trail from the original data to the final themes.

○ 6.2 Quantitative analysis

Data from the qualitative questions in the online survey were analysed using TA and NVivo, and the quantitative questions were analysed using SPSS, a statistical analysis package. This package was chosen for its relative user-friendliness and easy availability at the University of Sussex (Muijs 2010; Bryman 2012; Field 2013). Closed questions were converted to the numerical format required for SPSS, and statistical tests such as Chi-Squared were carried out in order to explore potential relationships between different variables in the data (Bryman & Cramer 2005) such as whether the independent variables of workplace and previous experience of mindfulness had a causal or associated relationship with whether a clinician would then refer a patient on to an MBI.

My data was also not sufficiently powered to be able to draw firm conclusions from the chi-square tests to test the association between different variables (Field 2013). Although the data was not sufficiently powered for conclusive interpretations of the outcomes of these statistical tests, useful data was also gained in learning of the *lack* of relationships between variables in the data. Any quantitative data used in the final analysis was thus used only descriptively to 'set the scene' for the study. An example of this use of the data was the mapping of current levels of MBI provision across Brighton & Hove and Sussex, and particular survey questions which established a picture of clinician attitudes towards clinical guidelines and EBM in their practice, and perspectives on the availability and efficacy of forms of MBI.

I also went through a learning process in realising in retrospect that I needed to have

tailored the framing and response-options of the survey questions with SPSS in mind, thus some of the output from the surveys was not amenable for statistical testing.

In terms of visual representation of the data I explored of Geographical Information Software (GIS) to map the current provision of MBIs across Sussex, but eventually used Batchgeo, data visualisation software, as a means of creating maps and graphs to explore relationships between key variables in a clear visual sense.

○ 6.3 Critiques of chosen analytic methods

Quantitative methods do not offer a simple solution to difficulties of validity, but as Fielding and Fielding argued, qualitative researchers need to have a 'warrant for their inferences' (Silverman 2011). There have been a number of recent critics (Carter & Little 2007; Green et al 2007) of the tendency for much qualitative data analysis to fail to make explicit the analytic process undertaken, with a common error highlighted being the 'spurious' correlations being drawn (Silverman 2011). These critiques reflected my own difficulties at the beginning of the study in understanding how to identify findings in the data. Analysis at the interpretative level attempts to identify *underlying* assumptions, ideologies and ideas. Thematic analysis did not allow me to make detailed 'claims about language use, or the fine-grained functionality of talk' (Braun & Clarke 2006: 97).

In terms of consistency of analytic approach across the work packages, TA was used for all of the interviews, with FA additionally thought by Ruth Chandler to be best suited for the data output for the RCT clinical team, whilst also allowing exploration of the slightly different concerns of myself and Ruth compared to the clinical team. The possible impact of FA not being used on all of the interviews was a lack of consistency in analysis (Silverman 2011), though this critique is undermined by the similarities of analytic processes between FA and TA.

More positivistic models of the 'absent or neutral researcher' are reinforced by computer-aided programmes for qualitative data analysis such as NVivo, which can give 'an air of scientific objectivity onto what remains a fundamentally subjective, interpretative process' (Mauthner & Doucet 1998: 122). Similar critiques have been raised by Gale et al on the charting process of FA (2013). The use of this software package for data analysis did not temper the influence of ontological and epistemological assumptions, as this program does not do the analysis, but merely

facilitated the systematic indexing and management of the data. More consideration could also have been given to the use of appropriate SPSS statistical tests *before* constructing the survey questions (Bryman 2012), which may have allowed for a clearer choice of analytic tests.

At the outset of the research I also had a commitment to action research as a particular theoretical framework. The initial ontological position that I adopted was driven by a hope to have a practical input on local mental health policy in terms of the provision of MBIs, with data grounded in the experiences of course participants. This position then evolved as I embarked on my fieldwork under further consideration of the practicalities of the time that the research process required. This was also data on the M4V RCT itself. Participant observation (PO) did not take place of the adapted MBI being delivered as part of the M4V trial for WP1, as the clinical team running the trial believed that my presence would affect the group dynamic of the course and validity of the trial.

- **7. Data reporting**

Green et al argued that the reporting of the analysis of qualitative research is often poorly described (2007), and that the credibility and validity for the strength of arguments produced have at times been based on the statement that a particular tradition of enquiry was adopted rather than providing adequate evidence of *how* knowledge and beliefs in a particular study were constructed.

As set out in Section 2 I believed it was imperative to contextualise the data presented and be transparent about my own subjective position as a researcher. At each stage of the study I did not consider the beliefs I formed to be occurring in isolation but to be a product of others that I held. These included beliefs based on prior experience, previous literature, and the nature of the social interaction occurring with study participants. I was aware that my analysis needed to include the way participants responded to the interview questions, as well as to myself as the researcher, and how I impacted on the interview situation.

Cooper et al identified potential difficulties involved in the feedback of interim or final findings to an RCT team and wider stakeholders, in particular reporting qualitative findings while a trial is still active (2014). Myself and Ruth were ready with analysis of our findings of the qualitative interviews with a sample of the trial participants before the main trial were. There was thus a delay in being able to pursue a full write up and

publication until the second phase of the RCT had completed their analysis.

Tong et al conducted a thorough review of existing checklists used to assess qualitative studies (2007). They devised a 32-item checklist of 'consolidated criteria for reporting qualitative studies' (COREQ) (ibid). I attempted to address the items on their checklist in relation to the methodology of my study, with additional comments on how these answers may have affected the validity and rigor of the study (Silverman 2011). Their findings resonated with my desire that the results of the study were accessible and meaningful to the stakeholders in the field of mental health, particularly the participants of the M4V trial.

The ethical basis of a research study is as important as its validity and reliability (Avis 1999; Hansen 2006). Qualitative research can result in detailed and personal exchange of information that may be of a sensitive nature or lead to ethical dilemmas (Silverman 2004). It is thus important that when conducting this type of research due consideration be given to how potential dilemmas might be dealt with whilst maintaining the confidential and anonymous nature of the disclosure in the research context.

- **8. Ethical considerations**

- **8.1 Risks to participants**

Qualitative research in the context of this study is non-therapeutic, and aimed not to provide improved health outcomes for participants but to improve knowledge, unlikely to benefit them directly but might benefit others. Because the study was run partly in collaboration with an NHS RCT, ethical approval was required from the Integrated Research Application System (IRAS), approval needed from the South East Coast & Kent Research Ethics Committee (REC), and consent to be obtained from the participants (Alderson & Goodey 1998). Participants had as much time as they needed in order to understand the information sheet and their understanding was checked before the interview commenced. The gaining of informed consent requires the provision of sufficient information for participants to be able to determine this. The consent form also requests that should they withdraw, I requested permission to use information gathered up until that point. Each participant was given a choice as to where they would feel comfortable being interviewed, in line with lone-working safety advice. No-one else was present during the interviews apart from myself.

WP1 interviews took place either at the location where the mindfulness group took place, at a Day Centre or Community Mental Health Team (CMHT) premises. Interviews with WP3 GPs took place in their clinical meeting settings. The length of the interview was determined by participants, although none exceeded 90 minutes⁴⁵. Participants were given details of the purpose of the investigation, how the study was to be conducted, how confidentiality, privacy and anonymity maintained, how the research might be disseminated and a written statement that they may decline or withdraw at any time from the study (*ibid*). Given the small sample size and purposive nature of the sample it was possible that individuals might be able to recognise themselves within both the results described and the quotations used as evidence to support findings (Hansen 2006). Pseudonyms were thus used to limit this potential breaching of confidentiality and give fluidity to the text.

In carrying out the study I aligned myself with the position adapted by feminist research concerning the researcher and researched, with emphasis placed on the potential power-relationships, and avoiding the exploitation of vulnerable participants. Proponents of this perspective (Ryan-Flood & Gill 2013) have also highlighted how power-relationships can change within a study. Initially a participant might share the balance of power in determining whether or not to participate, but it is inevitable though that once analysis and dissemination take place that power shifts to the researcher in control of explaining the findings and determining where and to whom they are reported. Transcripts were sent back to each participant to member check for accuracy and comment.

Feminist research has also stressed the importance of reciprocity in the research process, arguing that in asking the participant to share and engage within the study, myself as the researcher should be prepared to do the same. The purpose of this is to reduce potential power imbalances and exploitation from the research relationship. In carrying out the interviews I was aware of the balance of sharing enough of my experiences and self to establish rapport and encourage the participant to talk, whilst avoiding over-sharing with the potential to enhance exploitation, as giving the impression that friendship was being developed could have led to increased vulnerability and the potential power abuse by both parties (Grbich 2003; Silverman 2011). This was also a motivation behind my attending MBCT courses myself.

⁴⁵ It has been suggested that an effective semi-structured interview should be carried out for between 60-90 minutes (Hansen 2006).

Participants in qualitative research are vulnerable to psychological harm during data collection and dissemination, the risk of which I had to carefully assess during my IRAS ethics application. Non-maleficence in medical ethics is concerned with not inflicting harm intentionally and shows alignment with the test of 'best interests' (Beauchamp 2007). The related principle of beneficence is concerned with 'a moral obligation to act for the benefit of others' (ibid: 3) and one of the objectives of the study was to develop a practical model that might have the potential to improve referral pathways and awareness of MBIs in Sussex, and provide a case-study of implementation⁴⁶.

There was potential for sensitive issues to be raised and discussed by participants and the consequences of this had to be considered. During the interview it was possible that disclosure could result in distress as individuals confronted issues (surrounding their experience of hearing distressing voices in the case of M4V trial participants). Participation in the study was entirely voluntary, with no sanctions followed if the participant decided to leave the study at any time (this only happened in one case). The topic guides contained questions asking about participants' experiences of mindfulness exercises, their relationship with their body and overall sense of well-being and selfhood, as well as their personal experience of and views of mindfulness and its application for the experience of hearing voices. I was aware that these questions may give rise to a degree of emotional distress. Participants' knowledge of myself as the interviewer was non-existent before the interview, which always took place at first meeting. This did not allow time for rapport to develop pre-interview, though I only began the tape-recorder and the questioning after verbally asking if the participant felt ready. As an interviewer I had had experience in mental health and support work which involved one-to-one in-depth conversations with service users as well as experience of disclosure issues which had prepared me for the interviews. I did not uncover any information that required reporting to authorities (Tong et al 2007).

It has become increasingly recognized that qualitative research can also pose difficulties for researchers, though few studies have focused directly on researchers' experiences, and potential issues raised by their involvement in research (Lee-Treweek & Linkogle 2000).

○ 8.2 Risks to researcher

⁴⁶ Chapter 6 explores possible implementation collaboration with the upcoming implementation study being jointly run by Bangor and Exeter, Sussex being one of their sites (Crane & Kuyken 2013).

Kenyon and Hawker (1999) made the assumption that researchers will use common sense and intuition to avoid potentially risky situations. However, assumptions about which temporal and spatial situations are 'safe' and which are not, are highly cultural. Risks to researchers may include issues around the development of rapport, use of researcher self-disclosure, and feelings of guilt and vulnerability related to listening to untold stories. A recent enquiry, *Risk to Wellbeing of Researchers in Qualitative Research*⁴⁷ (Bloor et al 2008) highlighted past occasions in which qualitative researchers have entered the field without a full understanding the implications of the circumstances for their well-being, a situation paralleling a lack of 'informed consent'.

This study involved one-to-one interviews with people I had not met before, in some instances in their homes⁴⁸. Potential risks to myself thus included fatigue, emotional distress, and overburdening through the number of participants to be interviewed and the associated responsibilities. The questions I asked (see Appendix 7 for topic guide for mindfulness teachers) were not anticipated to be particularly distressing, but in terms of emotional distress, interviews have an effect not only on respondents but also on researchers. I felt emotionally involved with participants, particularly when the issues under discussion related to my own life and experiences. This process involved a certain degree of 'emotion work' (Hochschild 1990; Theodosius 2006), and I accessed the support of my partner, supervisors, friends and family to facilitate the 'emotion work' of the more demanding aspects of the study (Dickson-Swift et al 2009).

- **9. Conclusions**

Epistemological and ontological accountability is of more importance than precision of concepts and the aim of 'literal' accounting. Mauthner & Doucet have argued that if researchers could be more self-conscious about (and be able to discuss) their (embodied) role in the research process and its products, the more readers of these studies would have a chance to engage with and have confidence in the authors of studies (2003).

The 'use of multiple, integrated approaches is particularly useful in the evaluation of the effects of complex health care interventions' as these involve 'social or behavioural

48 One interview with WP2 took place in the participants' car in a car park of a train station, many in private offices in NHS buildings, others in public cafes.

processes that are difficult to explore or capture using quantitative methods alone' (Lewin et al 2009: 1). Quantitative research is often used to address typical questions raised in psychiatry, but qualitative research may be better suited to other questions arising from contemporary issues within this field, especially where intelligently combined with parallel quantitative research.

Methodological approaches to research enquiry are by their nature informed by epistemology, and I was able to demonstrate how my epistemological preconceptions led me to believe that it would be possible for me to access knowledge about MBIs in Sussex. The institutional, political, and interpersonal contexts in which I was involved played a key role in shaping my ontological and epistemological assumptions. A case-study was chosen as by its nature it takes a holistic focus, values experience, and 'seeks understandings which incorporates social context, and emphasise meaning over measurement' (Chamberlain et al 1997: 694).

Reality is contextually situated (and socially constructed) rather than a representation of 'truth', and research is an interactive process between the researcher and the subjects, with theories proposed a joint construction and product of interaction between participants accounts and how as a researcher I interpreted them (Mays & Pope 2000). Questions remain as to how researchers use personal and reflexive observations in data analysis⁴⁹. My analysis did not acknowledge all of the assumptions present in both my case-study and wider qualitative social research in psychiatry and mental health, and there were no doubt others that are either unconscious or not yet encountered, despite attempts to explore the processes by which individual subjective accounts are transformed into social science 'theory' (Bracken et al 2005; Mauthner & Doucet 2003).

49 See Mauthner & Doucet's discussion of the benefit of hindsight, amongst others (Mays & Pope 2000).

CHAPTER 5. 'LIVED EXPERIENCE'; EMOTION AND EMBODIMENT IN MINDFULNESS-BASED INTERVENTIONS

- **1. Emotions and embodiment**

This chapter addresses my first research question; '*What are mindfulness-based interventions?*', using the conceptual framework outlined in Chapter 2 from the research literature on emotion and embodiment to analyse the 'lived experience of mindfulness'.

Crucially, the contribution of sociological theories of emotions has included critiques calling for a rethinking of Cartesian dualism and biological essentialism (Milton 2005). Psychological and neuroscientific perspectives of emotion have tended to lack a holistic understanding of the mechanisms of emotions and their effect on the body, taking a cognitive, structural or psychoanalytic focus (Denzin 2009). As discussed in Chapter 2, emotions manifest themselves in bodily reactions, and have both cognitive and unconscious dimensions that cannot simply be managed via purely cognitive efforts. The focus of mindfulness-based interventions (MBIs) is on the *bodily* manifestations of emotions and the creation of a space (often associated with psychoanalysis) for the unconscious to arise. I will argue that this space lies beyond a state of rational comprehension (as in CBT) and has not commonly been the subject of examination or analysis (Theodosius 2008). Realist theories grounded in bodily experience have been useful in conceiving of emotions as multidimensional entities rather than as concrete or permanent (Pawson et al 2005; Theodosius 2008). Evolving perspectives have also included the interactionist approach (Hochschild 1983; Freund 2008) which viewed emotion through the notion of the 'mindful body', as the nexus of phenomenological experience and the body in its social context (Williams & Monaghan 2013 in Gabe & Monaghan ed. 2013: 66-67).

Emotions are fundamentally social, with corporeal, embodied aspects along with socio-cultural ones (Archer 2000; Theodosius 2008). This chapter will illustrate how integrative theoretical frameworks of emotion which incorporate 'the social' are able to illuminate my understanding of the data, and point to the need for a relational understanding in order to highlight connections between the mind, body, emotions and society (Cummings et al 2007; Burkitt 2014; De Leersnyder et al 2014).

This chapter argues that MBIs represent the latest form of the integration of emotions into mental health practice and theory. This argument is developed through the following three themes; first, understanding of the relationship between the mind and body, and how the embodied experience of MBI participants offers insights into theories of emotion. Second is the theme of emotional management, and the third, subject-hood. Tensions within the messages given in MBIs regarding the 'meaning' of emotion are identified, and discussions placed within a network of historically contingent social relations and practices within the context of Sussex, as well as the practice-based imaginings brought by MBIs that previous theorists have attempted to highlight.

- **2. Mind/body interaction within mindfulness-based interventions**

MBIs contain different kinds of physical practice that make different demands on the body. This section of the chapter considers the logic of these forms of bodily practice, and participants' focus on their levels of awareness of the effects of these practices, to explore my question of how MBIs are being engaged with and experienced. Meditation, the mindfulness of breathing, and the body scan were core components of the courses discussed by participants and will now be examined in turn.

- **2.1 Meditation**

Each of the weekly sessions of a standardised mindfulness-based cognitive therapy (MBCT) course contains differing lengths of guided meditations, none longer than 20 minutes. If a participant sits quietly and practices a concentrated kind of meditation, then the mind can become relaxed and calm, which in turn can often relax the body. This sense of relaxation is the most commonly studied impact of meditation in Western literature on this topic, with psychology texts usually mentioning meditation in these terms (and/or stress reduction) (Andresen 2000). Discussions of the meditation aspect of MBIs in the data were varied, as well as being from the perspectives of a mixed group of participants. For Helen the benefits of the meetings in themselves were this secondary benefit of relaxation:

I: Can you tell me a bit more about your experience on the course?

P: I think in terms of being able to relax, I think I was relaxing at a far deeper level that I'd ever done before, erm, some of the stuff I kind of knew, it kind of chimed with my own thinking about being in the world, relaxing in it, avoiding stress, getting out of stress and so on (.), but somehow, the meetings in

themselves, really, well just drew me into a place that I hadn't been to before I think.

The quieting of the mind's activity that comes from this form of concentration can be seen to give the individual more control over their thoughts, an effect which has significance in the field of Western psychology (Epstein 2008; Mikulas 2011). For MBI participant Hilary, learning to meditate was the primary satisfaction of attending the course, discovering that *'it wasn't actually as hard as I thought it was going to be, or whatever had put me off in the past'*. For another participant the meditation had helped her remain calm, even on holiday where she had not expected to have to needed it. Toby, who experienced distressing voices, was the only participant of the M4V trial to want *more* meditation at a *deeper* level as part of the course (he suggested transcendental meditation), as the MBCT course had not offered opportunities to go deeper and so acted more as a temporary respite technique. These responses can be compared with those of MBI participant Mark, for whom the attraction was the integration of mindfulness into his everyday life *without* having long periods of meditation. Observations were also made by a psychiatric nurse about the dangers of long periods of meditation, though this was mostly referring to *Vipassana* and *Insight* meditation courses, which involve extended periods of sitting in silence (Emavardhana & Tori 1997). Expressions of ambivalence and caution over aspects of MBCT imply a need to appeal to a diverse range of people some of whom might be put off by the meditation content (to be explored further in Chapter 7).

○ 2.2 Mindfulness of Breathing

The *'mindfulness of breathing'* or *'breathing space'* is a guided 3-step exercise/mini-meditation, aiming to bridge the longer, formal meditation exercises (franticworld.com: 19.6.14). This exercise focuses on the breath as an accessible anchor for the focus of attention, a practice supported by a wide body of literature (Kabat-Zinn 2011) as well as commercial businesses (Breathworks 2014). For MBI participant Yvonne, the mindfulness of breathing is at *'the core of the whole thing'*, the attraction being that *'you can be mindful of your breath wherever you are'*:

What tends to happen is that you start off in mindfulness of your breath, and you don't force yourself but keep going back to it, and then gradually...normally when I start off it feels like my thoughts are outside my head it feels like they're an outside force and they're pounding to get in, well they're already in!...And then gradually it's as though it quietens down, and then you get to a point where you actually feel as though you're separate, and your thoughts are somewhere else and you can watch them.

For Daniel *'the opportunity to touch base with it on a regular basis'* was the thing he most wanted to get from the MBI, and he *'resonated much more with the body scan and the focus on the breath, than with the movement exercises'*, while acknowledging the probable value in noticing that he found those areas of focus more difficult (Kabat-Zinn 2013).

Another exercise aiming to cultivate non-judgmental and flexible awareness of bodily sensations is the body scan.

○ 2.3 Body Scan

Body scan meditations invite individuals to move their attention around the body in a structured way, to take a curious approach to their experience and observe any sensations they notice. They vary in length but are usually 20 - 40 minutes long (Free Mindfulness 2014).

Comments made by MBI course participants centred on the benefits of doing the exercise lying down *'because it just feels more natural to close your eyes and lie down, because it's like you're going to sleep'* (Yvonne). Teresa said that with sustained practice she was much more aware of her body than she would ever have been before, and Helen that even over a short period of time the course made her realise that the mind and body are very closely associated, and to *'be much more conscious of how thought processes raise bodily reactions'*. For the M4V participants experiences were described as an *'energy rush'* (Toby), *'it makes my body feel numb and (.) that, but it's a good numb'* (Tony), or when done lying down on the bed *'felt like I was going to sleep'* (Debbie).

Another recurrent theme in the interviews with MBI participants was working through discomfort as part of the process within this exercise, with periods of sitting meditation initially often being difficult and uncomfortable. For GP Margaret, the focus of attention on particular areas of the body allowed the opportunity to edge in on areas of bodily pain or difficulty when the formal exercise was over. Senior Clinical Psychologist Brandon described his experience of sustained practice in Buddhist terms of having a refuge of calmness based on a developed sensitivity to the need to 'take care' of his body (Featherstone 2003):

I think, just gradually makes me more aware of my body (.), cause I, I don't think I was so embodied or aware of it (.), arguably I'm probably not very now but I

think I've, improved in that regard, I think it makes me (.) more sensitive to the needs of my body if that makes sense, in terms of taking care of it. Still, you know, there could be a lot more that I could do in that regard but, but I'm more aware of it (.) I think I'm more, I'm probably calmer, and I think more able to, to cope with difficulty, um, you know, more of a sense of (.), er, I think it's a Buddhist term in some ways but, a clearer refuge.

Online survey data supported that of the interviews, with clinicians stating: '*I found the experience of body-scanning relaxing*', '*the body scan particularly helped me learn to befriend sensations in my body*'. The scan is meant to have this effect, called such because of the methodical action of 'scanning' the body from top to bottom focusing on the sensations in each area in turn.

Perhaps unsurprisingly, the group of participants who seemed to find hardest the questions about how mindfulness affected their bodies were M4V trial participants. Bodies may not be considered a place of safety or refuge for this group, and some M4V participants such as Lauren did not like the body scan as it brought attention to areas of the body which were aching or in pain:

I: How was that for you, focusing on your body like that?

P: I don't like it really. (.) It, it takes the attention off the bad things though, and its quite interesting the way you just let the thoughts go through your head and you don't really do anything to them which is quite clever.

I: Mm, and what was it that you didn't kind of like about it?

P: I get aches and pains and like, when I was going through my body I'd notice all the aches and pains (.).

The contrast between Lauren's and the GP's position (above) on the experience of pain raised the relative position of privilege occupied by many of my respondents to be able to *seek out* the bodily discomfort brought on through these exercises. Individual's ways of relating to their bodies thus can be said to show the impact of the habitus and social capital (Bourdieu 1984, cited in Williams 1995; Williams 2006; Crossley 2013; Wacquant 2014). The unsuitability of the explicit focus on the body in this exercise if a person is, for example, experiencing a panic attack was also highlighted by M4V participant Lex:

Er (.) I just found it, when I did it, its meant to relax you but I actually found it made me a bit more anxious (.), because I suffer from panic attacks, and (.) when its all quiet and you're listening to someone speaking (.) and they're saying 'concentrate on your breath' (.), I concentrated on it too much that it kind of, I felt like I couldn't control my breathing and then I get a bit panicky and, it kind of just makes you have a little bit of a panic attack rather than chilling you out (.), so I wasn't too keen on that.

However for those M4V trial participants who had incorporated the mindfulness exercises into their daily life, bodily experiences seemed more easily describable. In terms of the longevity of the effect however, for the majority of M4V trial interviewees the body scan (and other exercises) was useful in terms of reducing the power of the voices while they were doing them, but the omnipotence of the voices returned soon after. Data exploring the experiences of M4V participants was analysed using framework analysis (FA) rather than thematic analysis (TA), but no discernible difference was found in terms of the conclusions drawn from these approaches.

Mental health nurse Steve discussed the relative lack of body awareness in the West (Barcan 2011), contrasted with the potential of MBIs to be *‘a very, very powerful healing technique if it’s correctly taught and maintained and (.) if the, if the patient is receptive’*. The importance of this receptivity and the factors which may lead to it are returned to in Chapter 6. This chapter now discusses emotions as fundamentally embodied through a discussion of how MBI course attendance affected participants’ relationships with their bodies.

- **3. Reflections on the mind/body/emotion relationship**

Individuals can reflect on the relationship between their mind, body and emotions through mindfulness practices. When asked whether attending an MBI had affected the relationship between their mind and body, one survey respondent replied; *‘Yes it has encouraged me to become more embodied, spending less time in my head’*. This comment had the interesting implication of a mistrust of the head as opposed to embodied feeling. This reflexive embodiment was made possible through a developing relationship with one’s body. Whilst MBIs may not use that precise language, they are aimed at this embodiment.

When reflecting on their experience, many respondents supported the seminal account of mindfulness (i.e. to develop awareness of links between the mind/body and help deal with stress). When asked whether MBI course attendance affected their relationship with their body, the vast majority of respondents to the online survey said that *‘More awareness of links between the mind/body/emotions’* was the main effect, with bodily experience being a means to this understanding. Thirteen respondents answered that attending an MBI had not affected their relationship with their body, or that they had not felt any benefit from the therapy in this way, with a lower number of people answering that attendance affected their levels of pain than expected from the

literature (Zeidan et al 2012). The focus of participants was generally on levels of awareness rather than symptoms (although interestingly some respondents *did* focus on their symptoms), suggesting a degree of regurgitation of core messages from the course. Indeed for some participants the direct repetition of the language used in the course (taken from the Buddhist mantra that '*this too will pass*') appeared to show the ideas conveyed in the course rather than the actual practices being beneficial. Eighteen months after completing the course, one M4V participant Harry found he could '*be aware of it [anxiety]...knowing it will pass*', and another participant could know that they were '*feeling awful now but know this will go...that this too will pass*'. The use of the same phrases as in the MBCT course was common in the data, highlighting the endurance of these materials in memory.

In this study statistically there was no significant relationship between the gender of respondents and changes in the relationship with their bodies following MBCT course attendance. MBI participant Helen discussed the awareness she had gained from MBI course attendance of how psychological processes manifest themselves physically;

Um, its certainly made me realise that, you know, mind and body are very closely associated, and its also made me realise, be much more conscious of how thing, er, um, thought processes, actually, raise bodily reactions as well, so I'm much more in tune with that, even after a short period of time.

MBI participant Mark admitted to '*a fairly low boredom threshold*' and preference for things physical, and compared his experience of an MBI with that of yoga in terms of gaining an understanding of the interdependence of the mind and body; '*I mean you can't sort of do one without the other really, without an awareness of your body, and your physical being, you can't have a strong awareness of your mind in some ways it seems to me*'. He found the opportunity to give in and sit or lie down for two/three hours '*really quite blissful actually*', in a way he had not got from yoga.

In terms of identifying mechanisms of change that lead to beneficial effects, in a follow-up of previous MBSR attendees, Kabat-Zinn stated that 86% of individuals had 'got something of lasting value' out of the experience, with the majority of changes including 'a new outlook on life'⁵⁰ (Halliwell 2010: 54). At times it was the 'reframing' – 'the

50 In terms of the M4V trial and the maintenance of on-going practice, it did not appear to be a matter of the length of the trial, but rather of people not being able to sustain practice long enough afterwards to benefit from the course on a long-term basis. Although many of the participants expressed regret at the ending of the course, this may have been the case even if the course was twice as long as the standard 8-week format; the benefits of a continuing supportive environment would continue to be felt, and problems continuing personal practice

change in perceptions of or response to symptoms, rather than a change in symptoms themselves - that alleviates a chronic health problem' (ibid: 52). The relationship between internal and external framing will be explored further in Section 4.1.1 below.

Before going on to look at emotional management, this chapter will pull together thoughts on the interdependence of the mind and body within wider systems, drawing on data where participants themselves reflected on this issue. Psychology has always struggled with dualism, targeting both the body and mind but as separate entities. The rise of talking therapies then focused on healing the mind, and mindfulness practice then brought the body *back* in and throws it back to the individual practicing and their own 'lived body' (Williams & Monaghan 2013 in Gabe & Monaghan ed. 2013: 66-67). This can have empowering results on the individual, as well as accommodating some of the individualizing tendencies of CAM and biomedicine. MBIS are thus not totally new in looking at the body, but are radical in the space that the practices can open up.

We have seen that MBIs can help illuminate links between the mind and body, and bring awareness of how thought processes raise bodily reactions, as well as knowing that difficult emotions which may arise will pass. This theme of 'managing' difficult emotions was recurring in the data and is now explored in more detail.

- **4. Emotional labour and management**

- **4.1 Key themes**

The practice of mindfulness and the development of psychological health can be most effectively explored in the context of Buddhist philosophy and psychology being centrally concerned with the removal of latent habits and tendencies associated with the bringing on and continuation of destructive emotions (i.e. anger), and the growth of 'positive' emotions (i.e. compassion or happiness) (Chambers et al 2009). Merleau-Ponty suggested processes of perception were bound up with intentionality, described as 'tending to the world' or 'a taking up of the world' (1996: viii), claiming that embodied skills are learnt by individuals as they interact with the world, and that this interaction produces habitual actions not requiring thought (ibid). Perception can thus be viewed not as a private representation of an external world, but an 'openness to being that

may have continued to occur. Those participants who sustained their own practice within the trial appeared to be those who found it easier to continue the practices after it finished.

occurs in-the-world' (Crossley 1995). Similar arguments can be made for the embodied knowledge that can be enabled and accessed through mindfulness practice. A key function of this 'embodiedness' is a particular approach to habitual emotions and thought patterns that arise. The more one can be grounded in the experience of the body, the better one can observe, rather than associate with, these emotions and thoughts.

Three key themes can be identified of the conceptualisation of emotional management by the different stakeholder groups.

▪ 4.1.1 Management of thought patterns

The first theme is the management of thought patterns and relationship with emotions arising from those patterns. Buddhist philosophy views 'mindfulness' as an important ally in the management of emotions (de Silva 2011). Ruminations, cycles of self-punishment and negativity, and clinical depression are also all things that MBCT aims to tackle. In responding to difficult emotions MBCT thus suggests the possibility of finding the gap between a trigger event and conditioned emotional responses to it, and using that pause to collect oneself and change habitual responses (Williams & Penman 2011; Kabat-Zinn 2013; Segal et al 2013). The metaphor of gaining respite from a '*washing machine mind*' was used more than once in the interviews, bringing to mind visceral images of cyclical churning and distraction. It was used in context of the regaining of a sense of control over spiraling negative thinking (Teresa), and the potential of mindfulness practice to interrupt these thoughts and allow the space to develop a more objective relationship with them.

GP Margaret described the common act of self-blame that comes from the thought patterns described above, and the way in which she has interpreted the MBCT mantra '*thoughts are not facts*', using the vivid metaphor of what morphine does with pain:

So, I very much use the concept of 'your feelings are just feelings' (.), and you're having them, you have nice ones and you have nasty ones and at the moment you're completely gripped, and so the job is to get a little bit of distance between you-, so you can look at it. Same way morphine does with pain, you know the pain's there but it's over there instead of there... And I think very much, I mean the principle of when you find that when you have yet again failed (.) ((slight laughter)) to focus your attention, you just regard it, you know, again, it's over there, it's not something to-. I think the thing (.) that I personally found most useful was getting hold of the idea that when you start to spiral downwards, then starting to kick yourself because you're spiralling downwards

isn't going to be terribly helpful. (.) And then just to 'Ah! Here it comes again' rather than 'here it comes again! Oh no! What have I done?!'. So, that I mean is a very useful place to get to, that a-, just letting go.

Mark also used the interesting language of 'relegating' negative thoughts and emotions to their 'rightful' place and in the 'retraining' of thinking:

What I felt was that, um, (.), that I was able to think on a very superficial level, and, and also become very entrenched in emotions that really took hold of me, and decided that, um, yeah and really kind of dwell on them, on the negative thoughts, dwelling on negative thoughts is quite a sort of big headline reason for me, um... And so, what appealed to me about it was, was to be able to retrain my thinking, so that I could (.) identify those negative thoughts, live with them, and sort of, put them in their rightful place, and come back to a more accepting way, not always a positive way but an accepting way, of thinking.

Also relating to the common 'stories' people's brains can tell themselves, one community course participant Hilary evocatively described a lesson she had taken from her MBI attendance as a '*new language and a new way of telling a story*'. Clinical psychologist Brandon described a process of de-centering rather than challenging the existence of particular thoughts. Another psychologist Philip discussed his frustrations at work, and that he found mindfulness practice both 'refreshing' and 'quite grounding', a way of de-prioritising things that he had thought of in the past as being important as well as emphasising what is sometimes forgotten. Mindfulness teacher Simon also nicely summarised the aims of emotion management, significantly *without* looking for an outcome:

Yeah, um, well one, I think one key element is that it's, um, it's helping people tap into their own resources, so, I mean there are other therapies that will do that, you know, so person-centered counselling for example. But it's very much, empowering people to, um, take care of themselves, so that's one aspect. Another aspect is, there is an absolutely pivotal and fundamental emphasis on being rather than doing, and it seems like, you know, the old emperor's new clothes story, you know, we have an expression when we teach; 'don't just do something, sit there', which is the complete antistudy to our whole culture (.), and it sounds like nothing, um, (.) but I think that is a quite kind of unique aspect of mindfulness, 'cause there's a lot of therapeutic approaches involved some kind of manipulation or working with something or, and there's some kind of outcome that you're looking for. And that's the radical thing about mindfulness, is that in one sense you let go moment by moment of looking for an outcome.

These data supports the proposition of MBCT courses which is to neither suppress nor express emotions, but to attempt to achieve a level of disengagement with the often compelling story they tell. See the popular *RAIN* formula as stated on many mindfulness websites (Audio Dharma Course 2014) below;

R: Recognize it. Name it.

A: Accept it.

I: Investigate it, be curious. What is it like, right now, this moment, in the body, heart and mind?

N: Non-identification (Not-me). This feeling is just a passing process that comes and goes, it's not who I am.

The advice given in this course is that sometimes it is adequate just to take the initial step, but that at other times individuals might need to take further steps to be able to attend to an emotion they find difficult (ibid). For M4V trial participant Lauren, her mind needed to be at a certain level to be able to cope with day-to-day life. Mindfulness exercises gave her ways to manage;

Like (.), when I'm say, hearing things, when I can do it, it's a sort of (.) bring my mind back down to a level where I can manage, and then I can sort of just - stop, finish doing it and then focus on not going into massive crisis (.), so actually it can be really helpful.

Beth also gained alternative coping strategies from the course and instead of following voice commands that before had been telling her to self-harm, she learned to switch off, leave her room and go for a walk. The exercises allowed enough space to cope with the distress caused by the voices. Some M4V trial participants learnt to let go of 'fighting' with their voices, or learnt to 'pick their fights better'. Two participants also described the effect of the mindfulness exercises as 'pushing the voices away'. These responses can be contrasted with the previous participant in terms of the element of retreat that was implied in the response.

In contrast to the lack of gendered responses (Section 3) regarding the impact of MBIs on their relationship with their bodies, gendered responses were evident in some of the interview data regarding facing rather than trying to fix or fight with difficulties⁵¹. For some respondents mindfulness fitted with their own account of themselves, that women already manage their emotions, and that mindfulness is not about fixing. One MBI participant saw men as having a 'fixer' mentality but women as being better at 'managing their emotions'. The implication for Mark was that by trying to continually 'fix' problems and difficult thoughts on a daily basis and fighting against them, they continue to dominate, as opposed to facing them as they are which then might reduce their hold over you:

⁵¹ A Pearson Chi-Square test was carried out to test significance of gender and whether a course had affected the ability to deal with difficulties, and no significance was found; Asymp. Sig. (2-sided) .869. The minimum expected count is 2.10.

It's not trying to get rid of them, and, um, and (.) and also, you know, it's interesting you say about interviewing blokes, well, um, you know, my, my sort of view is that a lot of guys (.) are, you know they've got a real kind of 'fixer' mentality, you know, if something's not right, it needs to be fixed. And, that's not to say that the genders are equally divided and that men do fix and women don't fix, but I think, um, women, tend to be a lot better at, um, I think they're a bit tougher about managing their emotions. I think they're a bit tougher about living with them and managing them, I don't think men are so good about accepting negative emotions I think they try and change it, they try and, they try and fix it.

The experience described above is in keeping with a commonly cited obstacle to the mindfulness of emotions as being 'the desire to fix uncomfortable emotional feelings by judging the emotion as bad, negative, unwanted', and the conflict that can come with trying to change these emotions (Kabat-Zinn 2011). As Mark stated; *it's a very, it's a very different way of understanding the world and understanding yourself than we're used to, particularly in Western society I would say (.) we're very used to if we've got a problem you've got to put your energy into fixing that problem, um = ((laughter))*'.

Teresa saw men attending courses as courageous, as sharing their thoughts publicly is not something societally supported or that comes as easily to men as to women. The admission of needing help in this sense may also be a potential barrier to attendance. Numbers also matter in a clinical intervention, and it would be difficult if MBIs only worked for either men or women (the vast majority of MBI participants being women). It may indeed be the case that the intervention works as effectively on either gender but that men perceive that as a therapy it is not suited for them, or prefer a more private mean of communication, as reflected in wider use of complementary medicine (Ernst 2000).

As shown through psychological research, knowledge can be gained through non-conscious processes (what is called implicit learning) (Cleeremans & Jiménez 2002; Casey 2005). This implies that not only can we know more than we can tell (relevant to difficulties in qualitative research), but we often know more than we realise (Polanyi 1958). Efforts to rationalise and explain non-conscious behaviour may then be experienced as counterproductive, hence the focus of MBIs in encouraging course participants to let go of the instinctive habits of trying to explain their inner thoughts and emotions (Leonard & Sensiper 1998). It should be noted that 'acceptance' of one's experience need not be equated with resignation or passivity, but rather 'refers to the ability to experience events fully, without resorting to either extreme of excessive preoccupation with, or suppression of, the experience' (Keng et al 2011: 1042).

▪ 4.1.2 Ability to deal with difficulties

A related theme to emotional management in the data was the ability to deal with difficulties resulting in part from the management of particular thought patterns, and the associated emotions that arise.

A clear majority of those SPFT staff who had previously attended an MBCT course (75%) found attending an MBCT course helpful in dealing with difficulties in their day-to-day life. Although there was not data on which course these staff had attended, many had probably attended the specific in-house training programme run through the Trust, indicating its success for staff wellbeing. Within this group the highest percentage of respondents (23%) answered that it had affected them significantly and 21% said that it had given them the ability to focus more on the present moment and be less reactive (see Appendix 8 for Table 2 of responses). Interestingly, 13% said that attendance on an MBI course had *not* affected their ability to deal with difficulties, which the interviews suggested in some cases to the lack of continued practice post-course, or a realization that this therapeutic approach was not suitable for them.

MBIs can be distinguished from other therapeutic approaches such as CBT through a recurring theme in interviews of the *practicality* of the exercises as a resource to be used in their own way. Exercises can then be part of a healing or preventative personal strategy, with the appeal also appearing to lie in the degree of simplicity. MBI participant Daniel discussed the importance of educating people about the availability of the exercises as a practical resource.

In terms of the impact of MBIs following completion of courses, comments regarding the need to '*keep up*' with levels of practice fit the theme of emotional management, with mindfulness as a fundamentally ongoing process. Many commented that this process was a necessary precondition in order to experience the nuanced benefits of the exercises. Several participants also used the term '*toolkit*' to describe their psychological resources for this management. Yvonne discussed the ability to deal with anger issues that have had a previous impact on her life, seeing '*it from the outside and feel it starting, and I can prevent myself from losing control, which is what happens when you get really angry*'. A comparison was also made by Mark to longer meditation practices within Buddhism as being less suited to the frustrations and difficulties of day to day modern life:

But I think when you're stuck in a traffic jam, trying to get into the Blackwall tunnel at seven thirty in the morning and you've been sitting there for two hours, then I think a mind of loving kindness is pretty difficult to, attain. (.) Um, whereas I think with the mindfulness thing it's, it's a pretty personal thing whatever state of mind you're in in fact it operates most effectively when you're in an agitated state of mind, it's your best friend at that point (.), as opposed to, some of the Buddhist practices that I've looked into which were, more about fundamentally changing your kind of view of things.

Interrelated to the practical tools and sense of control from MBIs are the role of emotional capabilities in being able to carry out (and resulting from) the mindfulness exercises.

▪ 4.1.3 Emotional capabilities

A recurring theme in the free text responses in the survey about factors affecting whether or not clinicians would refer was whether patients were '*stable*' enough to '*tolerate*'/'*come into greater contact with*' their emotions, and whether they had the '*emotional strength*' to do this. Coming into contact with emotions thus requires a particular toleration threshold (this is of course not something distinct to users of mental health services). The third key theme regarding emotional management in the data was the mental and physical capabilities needed to attend, and commit to, a full 8 week course.

As discussed in Chapter 2, my application of Hochschild's conceptions of emotional labour and management (1983), is to the management of emotions as enabled by mindfulness practice both within organisations and within individuals. Theodosius argued that the centrality of emotion, its interactive nature and connection to the self, was lost when Hochschild applied it to surface acting and deep acting, feeling rules and emotional management (2008). She argued that Hochschild did not define cognition effectively or differentiate between preconscious, conscious, and unconscious states. Part of the focus of MBIs is on cultivating a non-judgmental awareness of what arises in the unconscious and creating the space for this to happen.

The data suggested that MBIs can also be conceived as a form of embodied emotion work, and supports the expansion of the concept of emotion work through attention paid to embodiment. More than emotion work, the data suggested a certain level of emotional '*capability*' (author's term) needed for the mindfulness exercises and course

requirements, with capabilities here seen in the sense of capacities. 'Emotional capacities are part of the somatic or bodily dimensions of lived existence as well as being integral to the constitution of social and cultural life' (Lyon 2009, cited in Rottger-Rossler & Markowitsch ed. 2009: 201). Data from the survey on factors affecting whether or not to refer a patient to an MBI depended on whether the client expressed an interest in MBCT as a means of coping with their moods, or were able to sit with their experience, whatever that might be. For courses to be effective required concerted and sustained levels of mindfulness practice, whose continuation might be aided by a variety of non-specific factors⁵². Kabat-Zinn argued that, irrespective of their socio-economic status, individuals are always capable of contributing to their own healing (2013), though this position does not preclude the potential relationship between this status and emotional capabilities.

Helen commented that her fellow course participants said each week that they had not managed to do the homework. This tendency related to a comment by Clinical psychologist Brandon on the need for a client to be *interested* in learning to manage:

Um, whether, often its, whether (.), whether someone may be at the really acute stage of their difficulty, and is in a place where they are interested in learning something that may help them manage, and I guess hopefully improve their wellbeing (.), erm, and that that's going to involve turning towards their experience.

Being able to manage emotion within the expectations of a therapeutic group also emphasised 'the need to acknowledge the power of the social' in terms of emotional responses within this space; as socialised beings actors 'try to pay tribute to official definitions of situations, with no less than (their) feelings' (Hochschild 1979: 257). The power of *the social* lends support to the uniqueness of MBIs in terms of their relational emphasis and group format.

A wide spectrum of attendees came with differing levels of emotional distress and ability to pay tribute to what they saw as the official definitions of the therapeutic space. GP Eleanor made the important caveat about different people's ability and desire to be in a group environment (this relating to earlier discussions on variations in learning styles). This echoes the sentiments of some community participants as well as concerns from clinicians in the online survey about who they would consider referring:

⁵² These include the group dynamic, role of the facilitator, external stresses occurring in an individual's life, and the ability to pay for future follow-up sessions.

Mm, yeah, I think those (non-specific factors) can't be underestimated I think its really powerful being in a group of people, um, I've had a patient, I've got one caveat, especially people with mental health problems, I had somebody who was really interested and I referred her, and they got her to come along, and she kind of panicked on the first day, she couldn't actually handle being with a group of people (.) um, and, we'd discussed it before what it would be like, but I think you will get problems with people who are quite-, it's actually-, so to do the full kind of 8 weeks, it takes a certain type of person.

The difficulties in emotional management and the responsibility for, and turning towards, experience with self-compassion was recognised in the data, with mindfulness teacher Janet stating that:

Um, and you know I think its radical, you know sometimes people might think that its a bit soft and fluffy, but you know, I actually think that it, its (.) erm, it, its difficult and the sense of actually being able to turn towards difficulty, with support and compassion is um, not something that happens in, you know, say in CBT, it might be about changing what you think, and this is about turning towards it, with a sense of gentle acceptance. Which is very different.

GP Emma emphasised the importance of the motivation to attend and 'whether they really feel its for them, because I think if you really feel its not for you'll probably get nothing out of it, although you'd have technically done it, you know, done the course'. Mindfulness teacher Simon also discussed the broad spectrum of course attendees in terms of levels of emotional resistance:

*P: Um (.) yeah, well in terms of attendance throughout the course, um, I think there's several factors, so, so one is, and I think this is a key one, is how internally ready people are to engage with that kind of thing, I mean some people, for people who, just (.), I mean I'm blessed with the most amazing experience of having people saying 'this has been completely life-changing, in all sorts of different ways', and those sorts of people tend to be those who are just obviously really ready and really ripe, so I think that influences it. Um, how much people engage during the course um, also partly is kind of, what their lifestyle is like, some people are incredibly busy and they sort of realise, and = I: = just becomes about squeezing it in-between =
P: = yeah, and it's very hard. But also some people on the other side of the spectrum aren't ready, and they sort of come up against a lot of resistance in themselves*

Although all of the benefits of MBCT will not be gained if there is internal resistance, or the course requirements for home practice not adhered to, there may be a greater bodily consciousness when resistance of some kind is encountered (i.e. with practice of meditation, learning by coming back to the breath and overcoming discomfort).

Janet raised another point regarding the originality of MBIs as compared to traditional cognitive behavioural approaches, that they are not goal-directed nor do they encourage the challenging of thoughts, but instead to accept thoughts that arise without unhelpfully identifying with them (Halliwell 2010). In contrast, within the MBCT intervention, attempts are made to relate to and understand emotions while at the same time loosening their hold and their domination over the self in day to day life. One free-text comment however did state the importance of cognitive abilities in understanding the approach taken:

I think there are some people that just won't get on with mindfulness really, I think (.) you need a level of patience and concentration, to actually get into it enough to be able to use it, erm, and I think you probably need a certain level of cognitive ability actually, to, understand the approach, because it is quite a complex concept when you get into it really.

The importance of the commitment to attend all twelve sessions of the course was discussed by many of the M4V trial participants, though the 'lifeworld' of the M4V participants meant that attending regular therapeutic sessions was difficult, so the idea that this was about purely 'commitment' should be seen in a nuanced way. Interviews with M4V participants showed recurring accessibility issues in terms of the availability of follow-up therapeutic support for individuals following participation in an RCT of this kind and feelings of loss following the ending of the group. These feelings of loss follow from the ending of a regular supportive group environment, and the companionship and advice of peers and course facilitator. It was apparent that for many participants of M4V the very act of getting out of the house to attend the course could have as significant an impact as the course content or any of the particular exercises. This was an achievement and therapeutic goal in itself: a fact which deserves recognition by healthcare services.

In responding to Barker's arguments about the role of mindfulness in expanding the terrain of human experiences and problems defined and treated as an illness or disorder (2014), these links with medical thinking were not supported by the data. Respondents appeared to discuss mindfulness as an effective treatment for current conditions rather than the opening up of a more physical or existential plane of illness or suffering. The discursive frameworks I refer to are those surrounding the course content of MBCT, its predicted outcome, exercises, and home practice requirements. Participants did not seem to be aware of being shaped by these discourses, but willingly accepted the course form and content. The body itself may thus not be a 'discursive product' as claimed (see work following Foucault by Potte-Bonneville 2012),

as an individual's experiential and embodied relationship with their own body arguably cannot be imposed externally.

Chapter 2 laid out some of the current debates regarding self and subjectivity, and the interrelated nature of this area of enquiry with emotional management and the mind/body relationship. With these debates in mind the impact of mindfulness practices on selfhood and subject hood for study participants is now explored.

- **5. The integrated self**

'Unlike self-control, mindfulness is not primarily a tool to keep the self moving in a preordained direction. It is rather the capacity to, first and foremost, be aware of the ongoing parade put on by the self, including one's attempts to exert self-control. Indeed, mindfulness may even permit better choices about whether and when to control the self in the service of chosen ends, and when it might be better to step out of the parade' (Brown et al 2007: 277).

The self is both a target of interventions such as MBIs, and conceived on a conscious or unconscious level by individuals participating in (and being affected by) mindfulness practices. As explored in Chapter 2, Merleau-Ponty attempted to transcend dualistic terms and focused not on the body as such but on what it means to be 'embodied' (1996). The embodied self as the experiencing of the integration of the mind, body, breath, and emotions is a key goal of MBCT participation (Mehling et al 2011). Three interrelated themes surrounding subject-hood and the self were identified in the data; self-management, self-worth, and the self in relation to other.

The first theme was self-management and self-help, with 'self' referring to independence and the ability to be self-directed and do significant amounts of practice at home (as one clinician phrased it; *'all by themselves'*). The benefits of self-referral to mindfulness courses was also mentioned as a reason for the popularity of MBCT. In terms of the trends towards self-help, Clinical psychologist Brandon discussed new research areas currently being explored include an RCT based on Williams and Penman's (2011) self-help best-seller *'Finding Peace in a Frantic World'*. Mindfulness-based self-help (MBSH) has been the subject of numerous recent studies; resulting in significantly greater mindfulness/acceptance skills than control conditions (Cavanah et al 2014). That SPFT has individualizing tendencies can be seen in these trends towards MBSH.

The popularity of MBIs with clinical staff was also often attributed to the patient's ability to stay away from medication and the need for constant GP input. Of relevance to these claimed benefits for service users who heard distressing voices, The UK mental health charity Rethink have given a working definition of self-management as stated below:

Self-management is something we all do. It is whatever we do to make the most of our lives by coping with our difficulties and making the most of what we have. Applied specifically to people with a schizophrenia diagnosis, it includes the ways we cope with, or manage, or minimise, the ways the condition limits our lives, as well as what we do to thrive, to feel happy and fulfilled, to make the most of our lives despite the condition (Martyn 2002).

However, following critiques raised in Chapter 3, in the face of socio-economic factors and rise in discourses of self-help, concerns have been raised that the responsibility to meet need is being redistributed away from health services (Speed 2011, cited in Rapley et al 2011; Lupton 2015), and the economic burden associated with chronic illness away from the welfare state and public health services to 'private consumers' of healthcare' (Williams & Monaghan 2013: in Gabe & Monaghan ed. 2013: 66-67). The potential for this shift in responsibility was recognised in the data, by the same individuals (such as mental health nurse Steve quoted below) who remain within in the system in which these discourses are perpetuated:

It's tricky isn't it, um, on one level it's a very, very like, almost kind of middle-class kind of practice in some ways, and it's good for the sort of 'stressed professional', and it makes you wonder how powerful it could be with someone who's got real problems to worry about. Not just the fact they've got a stressful meeting coming up, and I mean a lot of it's... ((could not hear)) like that I mean we live in a very comfy world in a lot of ways don't we (.), um, but (.).

Mindfulness teacher Izzie discussed the impact of the funding cuts in the health service on the number of NHS staff on her courses, the individualizing of staff, and the need for more recognition of the emotional impact of stress levels on the ability to carry out the mindfulness exercises:

Yeah well its not to deny as well you know, in Buddhism we talk very much about (.) about em, how everything is dependent on cause and conditions none of us actually stand-alone we all need support from everyone else (.), you know, and if people weren't so flipping pushed in their jobs, why have I got so many NHS staff on my courses?! I ask you, well its because they're so over-pressured, cuts cuts cuts, too much work, you know. So, and that, to remove that pressure and to pay them more all and have more funding would make a massive difference to their stress levels and they could do more meditation (.). And that's the danger of getting into this individualised thing because you then say 'well its all your fault, if you can't be bothered to look after yourself' (.), but you're not looking at the factors why people maybe don't. You know, if they live on some ghastly housing estate and they've got to work 14 hours a day just to

pay the bills then how are they gonna get enough exercise how are they gonna find time to meditate?

The degree to which mental health can be self-managed relates closely to the second theme in the data regarding feelings of self-esteem and self-worth. Significant from the survey data as a result of MBI attendance and practice was the opportunity to slow down and provide space for the development of self-respect, with less onus put on 'problem-solving' and more on being and self-acceptance. Other comments included the benefits of being self-aware and more present, and through this the reinforcing of the idea of compassion *to* and acceptance *of* others. For mindfulness teacher Jane the MBI enabled her to touching base with her own emotional health in time of personal difficulty:

I mean recent, recently um, my daughter was diagnosed with cancer, in January this year, and I really believe that through my mindfulness practice, and the sense of, you know, really being as kind to myself as I possibly can (.), it's really helped me to manage and to really check in um, and to kind of ask myself 'what do I-, what do I need now?'

As a result of MBI attendance and practice MBI participant Yvonne also noted her desire to become a '*better person*', and the energy taken up by self-impression management in her day-to-day life. For MBI participant Mark (who had been taking medication for mild depression for a number of years prior to attending), the course helped to give himself a break and be kinder to himself, to '*not say 'look you've got this negative thing, and you're going to have to sort it out, if you don't sort it out, then you've failed, and if you've failed, then you're going to feel crap about failing'*'. For Helen the MBI also aided her ability to let things go, not hang on to things and to achieve a degree of separation between thoughts and selfhood, so that '*when something happens that is, is hard, I don't beat myself up about it, I think 'well, ok that's happened and I didn't get that right, and I've got to move on', you know, I'm not a bad person'*. These secondary emotions (emotions about emotions) are easy to reject or not notice, and this rejection can have significant mental and physical effects (Audio Dharma 2014). Also in terms of self-esteem, M4V participant Debbie felt she had gained a degree of control over the omnipotence of the voices, and increased feelings of capability through these feelings:

P: I just get a bit distressed sometimes, you know, if I'm having a bad session of it.

I: Yeah

P: Um, but I don't think 'oh I want to go round and chop their head off', I think I

might throw myself off Beachy Head but that's about as far as it goes, you know.

I: Mm

P: Its always aimed at me, the voices say 'kill your mum, she's talking about you' and I say 'No! I love my mum, love my dad, anybody', you know, its so hard.

I: Mm

P: That's why we need to have more groups like that.

I: Yeah

P: Because they do give you hope, they made me realise that you are worth something, you know (.), which we are, we're all worth something at the end of the day no-one's better than anybody else.

In psychosis, many positive psychotic symptoms can be seen as intrusions into awareness (such as through delusions or hallucinations), and it is the *interpretation* of these intrusions that can cause the associated distress⁵³ (White et al 2014, italics mine). In the M4V interviews, changes in attitude to those voices appeared to be associated with a reconceptualisation of the self as distinct from the psychotic illness and the negativity of many of the voices. Participants across three of the studies reviewed began to see themselves as distinct from the label of their illness, rather than 'being' the experience, rather than their identity being dominated by the distressing voices (Berry & Hayward 2011). The Chair Exercise in the adapted course was recurring in the majority of the interviews as trial participants' strongest memory. Taking physical action to choose to sit in the 'positive chair' appeared to bring on a strong sense of self-worth.

Beth:

Um, er, when we sat on the negative chair (.) and the positive chair. I sat on this chair and I thought 'I am worth, worth, worthy you know, I don't need somebody telling me I'm useless or (.), and then I said good things about how I felt about the voices, on the good chair, I sat on the positive chair you know, and that helped me.

Through this gaining of a sense of control also came a celebration of M4V participants own difference through interpersonal relationships and understanding the relationship between self and other. Participants made an association between their own voice finding and feeling in control in situations of social interaction, between feelings of alienation *and* openness to difference. These feelings entailed a negotiation of difference between and self and other. This becomes an affirmation and confidence

⁵³ Morrison argued that these interpretations can also be affected by a sense of 'faulty self', and that 'both the intrusions and their interpretations are maintained by mood, physiology, and cognitive and behavioural responses' (2001: 270). 'Self and social knowledge is in turn determined by experience' (ibid: 270), and can thus be developed through MBCT.

about difference (psychotic experiences being hard to hold). In Toby's case some paranoia about others in the group being all on drugs. Figure 8 below shows a screenshot from the SPFT Research Magazine 2015 Issue 5 (Sussex Partnership Research Magazine 2015), supports the benefits of a group environment as well as gaining a feeling of control;

Mindfulness – feedback from people who received therapy.

We asked two participants how they found taking part in the M4V study.

James

How did you find the M4V study?

"It was good. I got to mix with other people. It was bonding and understanding other people's problems and the exercises were excellent."

"I felt the therapists knew what they were talking about and they educated me quite a lot."

What was it like doing therapy with a group?

"Before I went it was a bit daunting. But when I got there it was great. I was well at ease."

What impact has the study had on your life?

"It helps me to shut the voices out when I do the exercises. It taught me A, I'm not alone with the problem and B, I can help myself."

Wayne

How did you find the M4V study?

"I liked it because it was in a group. I didn't feel alone. Meeting other people you know you're not alone. I liked the topics each week. Every time it was a different topic. I thought the therapists were really good. They really got how you were feeling on a weekly basis."

"They gave out MP3 players with the mindfulness practice on it. Techniques you can use. You can use the MP3 player to help. I really enjoyed the mindfulness study. I looked forward to it. It was a new study; you knew something was going to be done about it. There was going to be a response."

What was it like doing therapy with a group?

"I was nervous to start with. Talking about it and meeting other people, but once I sat down and started talking it was ok."

What impact has the study had on your life?

"I think what I got out of it was that there was light at the end of the tunnel and you weren't alone in it."

Figure 8: Screenshot from SPFT Research Magazine 2015 Issue 5 (Sussex Partnership Research Magazine 2015)

Following the celebration of difference that came from interpersonal relationships formed in the course, the third theme centred on relational understandings of the self and emotion. Sociologists have been cautious about stating whether there is a 'self' at all (Elliot 2007; Crossley 1999; Howson 2013), as individuals are 'constantly relating to and responding to other bodies, so our embodiment is never individual, nor processes in the body linear and simple' (Curtis 2012: 86).

Accounts in the data did not strongly suggest the imaginings of a singular self, but rather as an entity in need of support to improve feelings of self-worth and to support others. The literature indeed states that humans are 'loosely constructed selves that are continuous, various, ambiguous, ambivalent and creative', with the self appearing only in the communication between self and other (Burkitt 2014: 171) (see also Dawson 2013). The self is at the centre of a relational engagement with the world and with others, supporting the argument that 'at the heart of the self are emotional self-feelings that come from our openness to others in the social world' (ibid: 101). This openness is potentially enhanced by mindfulness practice.

A relational focus of selfhood is closely related to an emotional focus on a group therapeutic environment. Understanding emotions as integrally linked to the mind and body may be enabled by viewing them from a relational perspective, as according to Denzin 'all experiences of social emotion are situational, reflective, and relational' (2007: 3). Much of the data supported this understanding of emotion to be made possible through a group-based therapy such as MBIs. Mindfulness teacher Chris commented on the course's aim being for its participants to have a symbiotic relationship with fellow members of the group whilst also developing an individual capacity to practice and develop:

I think there's a great benefit in, in people being able to share commonalities of experience, um and, you know, the skill of specialised practitioners who are really able to understand and connect with, you know, sp-, specific experiences so, you know, I think as long as there's still that sense of (.) we're not working with (.) we're not kind of, you know, from that sort of perspective of 'what's wrong' but more, what can be nurtured.

These aims appeared to be born out in practice. MBI participants described the supportiveness of touching base on a weekly basis and working through difficulties they may have had during the week. Daniel commented that although the group may have had its ups and downs, there was a concern with listening to and helping each

other, and a respect that there were people from totally different walks of life coming together with a willingness to give it a go.

Social interaction involving more than two individuals with the same focus of attention can be seen as a ritual, and the outcomes – which Collins has termed ‘collective effervescence’ – can result in a sense of solidarity for an individual through a collective and emotional energy in an MBI setting (2004: 39). ‘Collective effervescence’, following the foundational work of Durkheim in the early 1900s to describe the effects of group religious practice, seemed suited to describe the interactive and relational aspects of emotion that go towards explaining the benefits of taking part in group therapeutic activities (1976). The concept of emotional energy ‘refers to a feeling of confidence, courage to take action or boldness in taking initiative. It is a morally suffused energy; it makes the individual feel not only good, but exalted, with the sense of doing what is most important and most valuable’ (Collins 2004: 39). This is an energy to be explored on an organisational level in Chapter 6. Mental health nurse Steve’s description of his MBI attendance hinted at the creation of this energy, positioning mindfulness as holding a key position within this process:

I: And do you have any other thoughts to add to that question about implementation?

P: I mean, what I would think ideally would be that if people who weren't religious really took to mindfulness that they would um, if they had a very spiritual experience then they might um, find themselves finding a, a value system that they didn't have before (.), and that could only be, be good really. You know you might find people um, turning to any religion, maybe it was one that they, that they come from or (.) that they go to but um, I think the sort of spirituality of mindfulness is, is sort of an essential thing within mindfulness, very healing and-, its like the sense of sacred that, that we've lost.

I: Mm

P: An amazing thing (.), its completely non-invasive, no drugs, no nothing just, just being.

Mindfulness as an intervention for Steve had spirituality at its heart, and a value-system that could be accessed by people without a previously religious background. It was also interesting that the non-invasiveness and benefits of *not* entering the body were highlighted by a mental health nurse, when the whole point of MBI are its physical effects rather than focus on the mind. This data brings a different perspective to Rose’s discussion of forms of therapy as potential ways to ‘endure the loneliness of a culture without faith’ (1998: 220). Steve’s statements also relates to the Hippocratic oath of the principle of *First do no harm* (Sokol 2013) that surrounds MBIs versus the more

nuanced forms of harm also identified in the data⁵⁴ (surrounding pain and bodily discomfort etc.).

Emotions are thus vital to wider wellbeing, as eloquently expressed by Williams; ‘without emotion, society would indeed be an empty, dull, disenchanting affair, with little or nothing to commend it. From this viewpoint they are ‘enchanted’ ways of being-in-the-world, rendering our own and others’ embodied conduct both meaningful and intelligible’ (2005: 140). What then becomes important (and what is highlighted by MBCT courses), is the potential through disciplined mindfulness practice to develop an embodied sense of interconnection and ‘empathic proximity’ (Braidotti 2013). This interconnection in an embodied sense was evidence in the data and is the subject of Section 6 below.

Results of the M4V trial that seemed to stem centrally from being in a group included: the association of own voice finding with practicing maintaining control in situations of social interaction, and the normalising and validating associated benefits of connections made between group members. The importance of the peers in the group was commonly stated as a strong memory of the course, centrally the stories each person told about their own experience of voices and attempting the exercises. For others, the benefits of course attendance were often compared to feelings about being part of previous group therapies that were *not* MBCT, and their feelings of anxiety and nervousness in expectation of attendance on the MBI, with previous feelings of panic overcome. Debbie compared the MBCT course to a previous group she had attended on relaxation for anxiety. For her the MBI required more of a concentrated effort to focus on sensations in the body, and the feeling of relaxation was a by-product of this effort, highlighting that it was not just the therapeutic group environment but also the particularities of MBI practice:

I: Had you done anything like that before in terms of like focusing on your feet and how they felt (.), how different bits of your body felt?

*P: (.) Um, only (.) years and years ago I went to a little group um, I think it was for anxiety down at ***** hospital, and we used to do relaxation, um, exercises. But this was different than that because they say that its not about relaxing. But it does relax me (.), um its about focusing on the sensation in the body, which is quite right 'cause its different from just sitting there and relaxing. (.) It's hard to*

⁵⁴ These principles can educate, reinforce professional behavior, and inform clinical judgement. They can also help to construct professional identities (Sokol 2013). A central difference between MBSR and Buddhism is that in the latter, mindfulness makes up only a small part of a set of practices within a distinct set of spiritual and ethical principles (Shonin et al 2014). This is different from the within MBSR, which are embodied by the Hippocratic Oath (First do no harm).

explain what it does it does you, you have to have gone through it (.) the experience of hearing distressing voices, um, then taking part in the group and learning how to do the relaxation. =

I: Mm =

P: To sort of understand how important it became (.)

I: Mm, and you're not thinking beforehand; 'i need to relax'? =

P: No you don't, you just try and clear your mind (.) and focus on (.) nothing, because you're just trying to like I say start with an empty mind, which when you've got all this shouting and stuff going on can be really hard.

An awareness was also evident in the data of the group as both a resource and threat, with some people finding aspects of the group format unhelpful. Mindfulness teacher Izzie drew this comparison between group-based and one-to-one therapeutic approaches, discussing the important caveat of the broad variation in learning styles and the group-based format will not suit *all* participants:

*'A person gets to talk about themselves all the time (.), but they lose out on hearing about other people's experiences and in 8-weeks, which is actually quite short then you know, a couple of months down the line something might happen and you might go 'ah I remember that happening to so and so!' and '****' said this'. You know, some people learn quite well from other people's experiences and other people don't'.*

- **6. Conclusions: embodied relationality**

Through emotions, 'bodily, psychological and social phenomena can simultaneously be represented and explored' (Lyon 1996, cited in Williams 2006: 146). In examining how emotions feature in accounts of experiences of MBIs, the data in this chapter found that people *did* narrate the link between the mind and the body, including the dangers and nuanced risks of this engagement such as noticing particular aches and pains to an increase in voice-hearing distress. The data added weight to the countering of dualistic binaries, such as further questioning lines drawn between 'reasonable' and 'irrational' emotions (Solomon 2000, cited in in Lewis & Haviland-Jones 2000) through participants' awareness of the emotional basis for their varied mental states. Mindfulness practice provides a space for reflection on emotions which arise without judging or associated with them as a form of selfhood. It was clear from the interview responses as well as comments from the survey free-text data that the body is both a central component of MBCT courses, and can come to be experienced as a source of mental focus and embodied sense of calm.

Mindfulness practice brings the body back into central focus (post CBT and talking therapies); taking emotions seriously but not letting them dominate for the individual. To the extent that this encourages individuals to engage in work with and on their emotions it might be seen as the latest incarnation of a whole series of techniques by which modern organisations encourage emotional management as a form of emotional labour (Hochschild 1990). However my use of that term is not intended to suggest that this is necessarily problematic. At least some respondents found this felt like freedom from previous therapeutic approaches (especially medication), and the request that they took some individual responsibility for relating to their feelings an opportunity to reclaim the 'self' and a sense of control that had been lost.

Similarly the delivery of MBIs in groups could be thought of quite critically as money saving, though members of the M4V groups in particular also talked about regretting or fearing the end of this regular group contact which they had grown to value, again in distinction to the pharmaceutical or talking therapies otherwise offered in the Trust. The MBCT course is a discursive product, as are the subjective interpretations of those exercises aimed at bodily experience. This need for sensitivity to individuals adds to the argument that MBIs cannot be delivered as a manualised intervention.

Practical awareness of group-based relationality was evident in much of the data. Relational theories of the body were also supported through the biological body being seen as a manifestation of the social, in well evidenced physical effects of stress, and the concurrent impact of MBIs on awareness of links between the mind and body. Through a rethinking of the biological in a non-reductionist way, biology can be incorporated into sociological theory as a necessary foundation for bodily and emotional experience (Williams & Bendelow 1998). In the light of findings from this study, biology can thus be seen in terms of the transformative (and potentially radical) potential of MBIs to increase embodied knowledge. Data on the specific impacts of mindfulness practice on the relationship between the mind and the body supported this position.

The transformation potential of MBIs is structurally conditioned however, with societal structures key in transforming biological dispositions into attributes and skills defined by society (Williams & Bendelow 1998). The data showed that not all MBCT course participants have, or develop, the same relationship with their bodies. Identifying what happens emotionally in a group that may be particular to MBCT alongside non-specific factors remained a difficult task, and a recurring question was how to identify the

effects of personal practice from the non-specific factors resulting from a regular and supportive group environment.

Holmes proposed emotions as 'central to a subjectivity and sociality that is relationally constructed, crucial to how the social is reproduced and to enduring within a complex social world' (2010: 139). Concepts of emotions are thus integral to wider conceptions of selfhood (Finkelstein 1980; Fox 1998), and paying attention to emotions can thus be a way of being able to include more aspects of one's present moment experience.

The impact of mindfulness practice on the management of thought patterns and the corresponding impact on the ability to deal with difficulties in day-to-day life were identified. In terms of capabilities, the identification and balancing of non-specific factors within the M4V trial was a difficult process. Mindfulness does not deal with the causes of distress, and socio-economic inequalities continue to be integral to any analysis of the impact of MBIs on an individual's emotional and embodied wellbeing. The contribution of MBIs to developing understandings of embodiment can also be seen as beyond the realm of micro-individual relations, and as potentially 'institution-making' in terms of the effect that the embodiment of particular qualities in certain opinion leaders can have on the 'emotional climates' within organisations (Csordas 1994; see also Basso & Oullier 2010). The following chapter develops these discussions by exploring how the sociology of the body, embodiment and emotions plays out through the innovation of the particular application of MBIs in SPFT and the wider Sussex context.

CHAPTER 6. INNOVATION; EXPANDING THE REACH OF MINDFULNESS-BASED INTERVENTIONS

- **1. Innovation in context**

This chapter addresses the research question of who is promoting and working with MBCT and how this innovation acquires currency in Sussex Partnership NHS Foundation Trust (SPFT). Mindfulness is not just a practice but an innovation, and this chapter provides an insight into how it is practiced within the Trust.

Literature on innovation within healthcare helped me understand this question, and this study follows a working definition of innovation as ‘a process of translating an idea or invention into a good or service that creates a form of value for patients’ (Sgroi 2014: 73). Healthcare has experienced a growth of innovations aiming to increase life expectancy, quality of life, diagnosis, and the forms and cost-effectiveness of treatments. Despite this growth there has been limited theoretical research in this area.

This chapter examines how innovation as a term has been applied to MBCT, what this means, and on what authority such claims are based. ‘Modernisation’ is a central objective of UK health policy, and representing a particular set of values; opening up of providers for choice and competition, improving financial performance and promoting efficiency (Wilkinson & Gale 2015). NHS responses to mindfulness-based interventions (MBIs) can be used as a medium for understanding the shifting definitions of innovation and understandings of how it happens within this context.

MBIs were introduced in SPFT with reference to both formal scientific evidence and experiential knowledge of its practical benefits. These strands have been brought together through both local champions and opinion leaders, the former being key individuals willing to support this innovation, and the latter those embedded within the networks of the Trust with a particular influence on the actions and beliefs of colleagues (many individuals of course occupy both of these positions).

A key sociological question therefore is how innovation is done – or has to be seen to be done – how new treatments are introduced, what link is made between production of evidence about them and such ‘implementation’. Innovation is seen as positive within the NHS, though is not always linked to evidence. Of equal if not more important to the evidence are social factors and levels of trust in peers and particular data sources. The activities of key individuals involved in MBIs in the context of Sussex took place within a compressed timeframe, with the same people carrying out the research

as promoting the mindfulness agenda. Evidence generated for the efficacy of MBCT for particular patient groups helped create 'trust' – without mattering that a trial is finished or not. This is particularly important in regard to a therapy that might have reputation problem as being 'fluffy', but equally becomes possible when no one thinks the therapy could be harmful, when not suspicious of trials as commercial (as could be the case with pharmaceutical trials), and when trial is being carried out by known local personalities.

The central focus of MBI activity within the Trust is through the Sussex Mindfulness Centre (SMC). This grant-funded virtual centre (see Figure 9 below) was formed by a group of individuals, within the Trust in 2012, many of whom are champions of MBIs. The SMC claims to take a multi-targeted approach, which aims to allow MBI training, practice, governance and research to work together effectively (Sussex Partnership 2014).

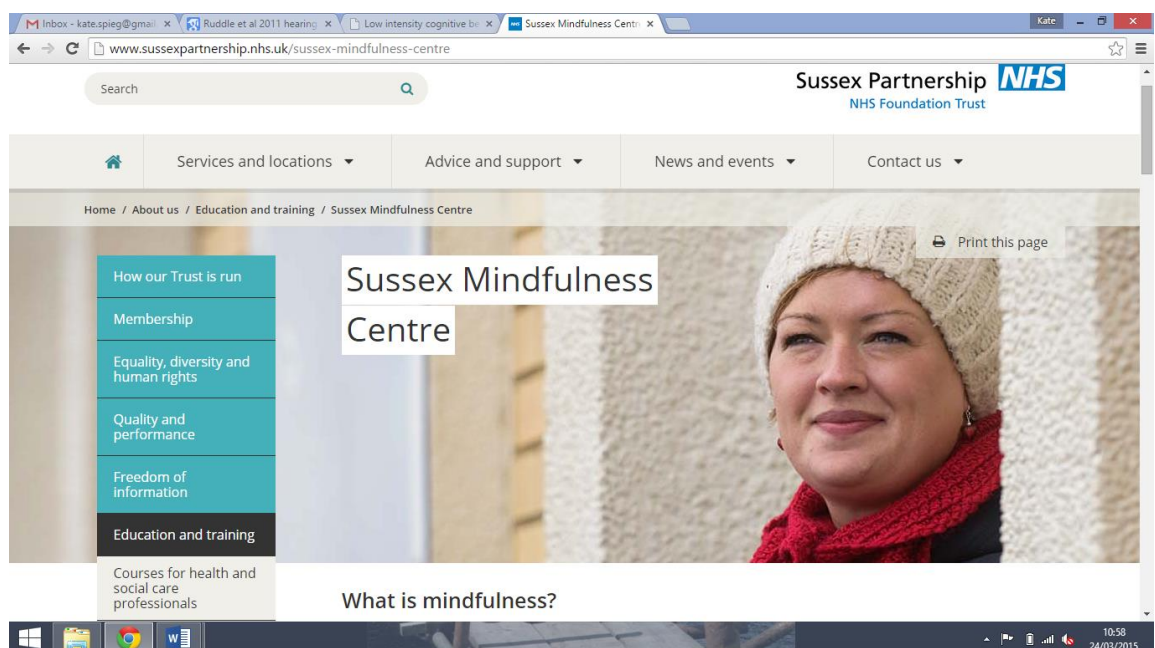


Figure 9: Screenshot of home page of the Sussex Mindfulness Centre (Sussex Mindfulness Centre 2015).

The SMC is an organisation specifically designed to do research within Sussex, to produce data that would influence people at a national level, and develop a broader sense of the Trust as a research actor. It provides adaptations to MBI courses, and continual professional development (CPD) through a series of mindfulness 'Master-classes' (£75 per day session) (Marx et al 2013). It is also the coordinator of the MBI training programme, a strategy (defined here as a plan of action that is designed to

achieve a long-term aim) of the opinion leaders to embed the running of MBI groups within different SPFT services, as well as a means of evidence dissemination.

Emotion(s) and experiential knowledge cannot be separated from the way people work with, and respond to, evidence and innovation (Bolton 2000; Barbalet 2002; Pickersgill 2012). Whereas Chapter 5 had a focus on the emotional experience of individuals in a group MBI environment, here the collective and institutional aspects of emotion are explored. This chapter thus has a dual focus: first in terms of what forms of evidence signal legitimacy for the MBI innovation, second in terms of the emotional climate of SPFT, how the momentum behind MBIs came about, and how concerns over its implementation were narrated.

- **2. Evidence**

It has been recognised for over four decades that evidence-based medicine (EBM) is not an entirely 'rational' activity (Gupta 2011a). As discussed in Chapter 3, this recognition in the literature has led to studies exploring the impact and transfer of forms of knowledge that may not conform to EBM as traditionally viewed. One example of this area of enquiry was Fairhurst & Huby, who differentiated between 'formal scientific trial data' and 'practical knowledge', exploring how clinical evidence is integrated into general medical practice⁵⁵ (1998). Integral then to the regime of EBM are positions and practices around collective thought (Karuza et al 1995). A central means of exploring responses to trial data and application of evidence in the Sussex context is through the use and interpretation of the evidence-based guidelines (EBG) set by the National Institute of Health and Care Excellence (NICE).

- **2.1. Evidence appraisal**

Since MBCT became included in the NICE guidelines for recurrent depression in 2009 (and in the 2013 update), its roll-out and evaluation takes place according to these evidence-based parameters (National Institute of Health and Care Excellence 2014). No formal application of this intervention took place either within SPFT or the NHS more widely before this time. Standardised practice guidelines such as NICE aim to tackle the ongoing variations in clinical practice (Timmermans & Mauck 2005) and to

⁵⁵ Practical knowledge here referred to the influence of a consensus amongst peers on how GPs assessed and used evidence (explored further in section 2.2 below).

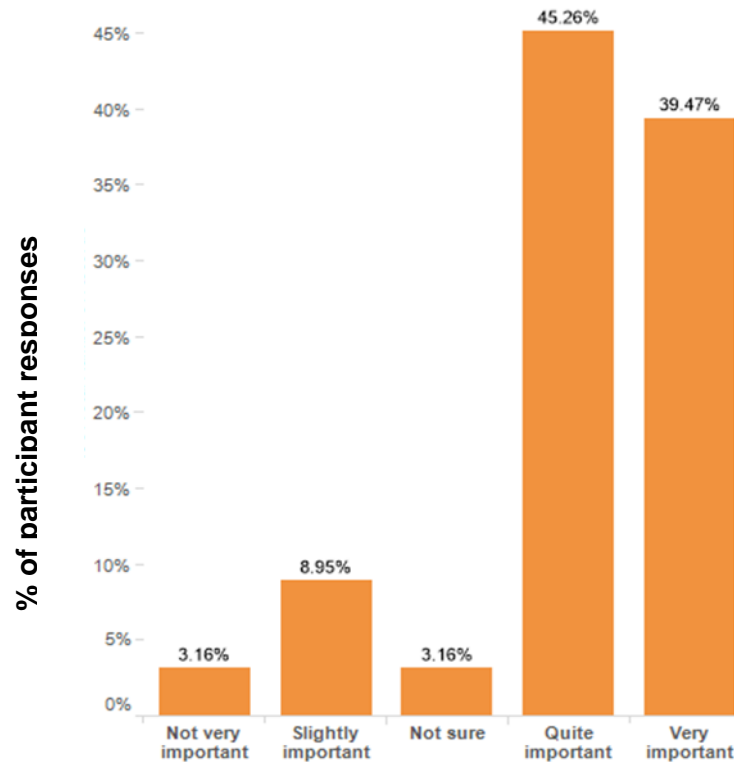
make recommendations based on both clinical and cost-effectiveness (Wonderling et al 2011). MBCT was seen by the NICE committee to adhere to these requirements.

Rigorous evaluative mechanisms are a commonly accepted means to establish an evidence-base, and were presented by several participants such as psychologist Peter as particularly important in the case of MBIs because of countering instinctive reactions to the therapy as *'soft and fluffy'*:

Yeah well I mean we, are quite strong believers in being empirical about this stuff. And I actually think in an area like this especially, where you get onto well-being, um people instinctively think of it as soft and fluffy, so there's almost an additional reason why you want to evaluate as hard as you possibly can, um, in order to almost deal with the politics as well as the basic empirical question.

This use of language fits discussions in the literature on CAM in the NHS on the dichotomous framing of many approaches under this label, and the equating of these terms with complementary therapies in popular discourse (Boon & Kachan 2008; Bates 2013; Gale 2014).

In terms of the impact of NICE on the day-to-day practice of the clinical survey respondents within SPFT, 92 respondents (45%) answered that the NICE guidelines were *'Quite Important'* and 76 (39%) that they were *'Very Important'* to their day-to-day work (see Graph 1 below). Influencing factors may have included the influence of NICE on referral and prescription decisions, as a point of reference or consultation, or that clinicians were aware that the expectation was that their practice should be based on these guidelines and so answered accordingly. In comparison, other earlier studies reported that practitioners rely mainly on clinical experiences when making decisions regarding treatment, whilst also consulting EBM literature (Stewart & Chambless 2007).

Graph 1: How important is NICE to your day to day work?**Participant responses**

In a survey sent to psychological therapists, Gyani et al recently 'reported that research had little influence over their choice of theoretical orientation and clinical decision-making compared to other factors', specifically clinical experience and supervision (2014: 199). Compared to GPs and nurses, mental health practitioners have been cited as the least likely to see others' guidelines or protocols as the best source of evidence (O'Donnell 2004). That these studies did not correspond with the survey data might suggest respondents within Sussex to be more research-minded, or that as a researcher aligned with SPFT I was given the answers that informants believed would be best suited within the very evidence-focused organisation of SPFT.

An evidence-base supported through NICE was stated in much of the data to be a source of authority (McCabe 2008; Kelly et al 2010; Wonderling et al 2011). Trainee psychologist Tilly saw it as helpful that mindfulness was associated with an evidence-based therapy such as cognitive behavioural therapy (CBT), but because of their different philosophical underpinnings remained unclear about how the two models worked together. The utility of qualitative research was also acknowledged by policy-makers as a useful supplement to RCTs (potentially in understanding Tilly's reservations). Policy-maker Peter argued however that although there were clinicians

who had experience of mindfulness or listened to positive feedback of it from patients who valued it, they would nevertheless '*always come back to the evidence*'.

The volume of guidelines sent to GPs however does not make either referral or treatment decisions easier, and GPs also reported difficulties in accessing them⁵⁶. Implementation of NICE guidance has often been variable (Dent & Sadler 2002), and the diffusion of innovations literature has indicated that the adoption of NICE guidance depends on key factors; the extent to which managers and practitioners see advantages to taking them up, whether there is clear evidence, and the degree of professional endorsement (Sheldon et al 2004). The data supported all of these factors, suggesting that patients could benefit from MBCT *without* an RCT. Respondents to Fairhurst & Huby's study interpreted the trustworthiness of the source of the evidence within the context of the social and economic factors that affected their routine practice (1998). It could thus be argued that trial data becomes relevant only when this form of consensus exists. My data supported this study, with a lack of both the skills and time to critically appraise evidence cited, as well as the need for increased resources and training (O'Donnell 2004).

This area of enquiry serves to highlight the contested aspects of acquiring scientific knowledge, as well as the interactive nature of its diffusion (Fitzgerald et al 2002). This chapter now situates these discussions within the context of SPFT.

- **3. Sussex Partnership Foundation Trust (SPFT)**

- **3.1 Organisational Narratives**

This section explores the position of the Trust in facilitating the creation of evidence, and the narratives it uses to describe this position. Figure 10 below shows the scrollable homepage of the website of SPFT (upgraded in early 2015), note the emphasis on '*Promoting positive mental health, wellbeing and recovery*' on the first page and an emphasis on diversity through the person depicted.

⁵⁶ Clinical guidelines can also be seen as restricting GP's freedom to make their own decisions (to be explored further in Chapter 7), though this was not commented on in the data (Armstrong & Ogden 2006).

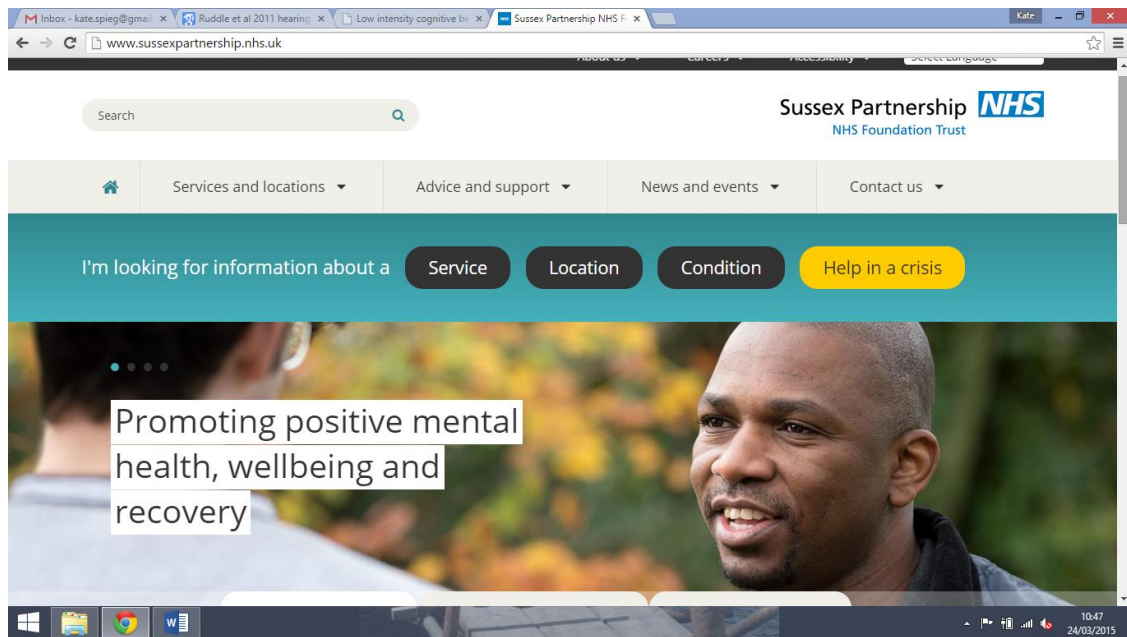


Figure 10: Sussex Partnership Foundation Trust website homepage (Sussex Partnership Foundation Trust 2014)

The research team at SPFT was the winner of the 2013 '*HSJ award for Clinical Research Impact*'. Figure 11 below shows the Research and Development (R&D) Team at the SPFT Research Conference 2014 with the HSJ Award.



Figure 11: SPFT Photographer (2014) SPFT Research and Development (R&D) Team

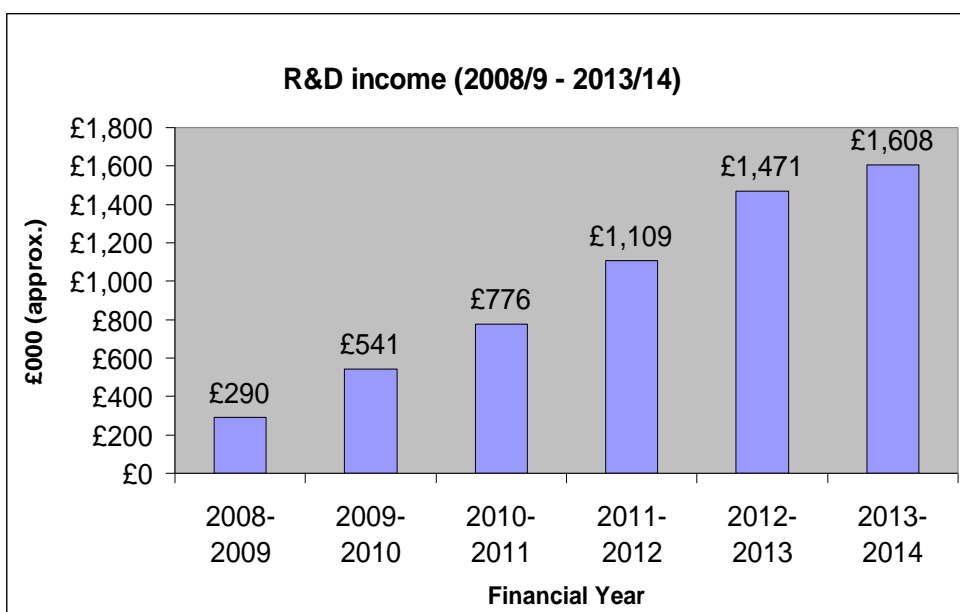
The R&D department began in 2007 with 2 staff and for the year 2007-2008 had a £290K income, 8 (high-quality) studies with 172 participants and 2 events. In the year 2013-2014 the department had grown in six years to have 77 staff, a £1.4m income, 46

studies with 1370 participants, and held 21 events (see Graph 2 below of R&D income over this period).

Graph 2: SPFT Research and Development Income 2008/9-2013/14

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Sussex Partnership **NHS**
NHS Foundation Trust



The Trust has been credited with a 'robust research strategy, good communication with researchers, patients and carers and support from NIHR Networks that raised the awareness and increased participation in clinical research' (Sussex Partnership Mindfulness Research 2014). SPFT has been holding annual R&D conferences for 7 years, predominantly held at the University of Sussex, with the last audience of 200 people.



Figure 12: Ruth Chandler (SPFT Photographer 2014), service user and carer involvement co-ordinator for SPFT, with whom I was working in collaboration on the M4V trial.

In terms of service user involvement, an Expert Patients Programme (EPP) was integrated in Sussex in 2011 bringing the Brighton & Hove team and West Sussex team together under the Wellbeing Services (Sussex Partnership Expert Patient Programme 2015). The Trust was also runners-up in the '*Health Service Journal Awards*' for the involvement of service users in their research, an area of work led largely by Ruth Chandler (see Figure 12 above). Interactions between service users, managers and professionals reflect wider tensions of settings in which 'officials' and 'users' interact, and conflicts between institutional norms shaping participatory practices, and the reasons that lie behind participation. This resonates with conflicts that became apparent in the M4V RCT between the LEAP and the clinical team (MacDonald et al 2014).

Research funding received for mindfulness trials and training through the Sussex Mindfulness Centre (SMC), has also led to the claim made by SPFT to be the 'market leader' in the field of MBI research (MacDonald et al 2014), a claim made on the basis of the number of publications and research funding gained.

Ongoing research in progress through the SMC includes a Two Phase RCT investigating the efficacy of online mindfulness-based self-help (MBSH) for staff (Cavanah et al 2014), a PhD on the mechanisms by which mindfulness works such as an increase in self-compassion and reduction in rumination. Research posters such as Figure 13 below produced by members of the SPFT (and led by the Research Lead for the SMC) evidence some of the Trust's other research output. The purpose of these

posters was for display at the annual Research & Development SPFT conferences, but they are also shown at the Sussex Education Centre and circulated through the SPFT Research Magazine, as well as at other academic and health-related conferences the authors of the studies may be attending. The imagined audience of these posters is thus both members of the Trust and the wider research community.

TURNING POINT
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Lightmind

Low Intensity Guided Help Through Mindfulness

Background

The National Institute of Health and Care Excellence (NICE, 2009) recommend psychological interventions for depression including cognitive behavioural therapy (CBT) and, for relapse prevention, mindfulness-based cognitive therapy (MBCT). However, demand exceeds supply, so NICE recommend that in most cases of mild or moderate depression CBT self-help materials should be offered along with brief support from a mental health worker. However, about one third of people starting CBT self-help for depression drop out, and about one third of people do not benefit even when they complete the intervention (Kaltenthaler et al, 2008).

Mindfulness has been defined as the capacity to intentionally pay attention to current experience (thoughts, feelings, body sensations) in a non-judgemental way (Kabat-Zinn, 1994). MBCT is a group therapy for depression that adds mindfulness meditation practice and principles to cognitive therapy. There is evidence that MBCT is effective in preventing relapse for depression (Kuyken et al, 2008; Ma & Teasdale, 2000; Teasdale et al, 2000) and reducing symptoms of depression (Strauss, Cavanagh, Oliver & Pettman, 2014).

Self-help materials based on MBCT principles might be attractive to and effective for some people experiencing mild or moderate depression. However to date, high quality research has not evaluated the benefits of self-help MBCT.

Our recent randomised controlled trial (Lever-Taylor, Strauss, Cavanagh & Jones, under review) evaluated an MBCT self-help book (Williams & Penman, 2011) in a student population with people self-reporting distress. We found significant improvements on symptoms of depression for intervention participants in comparison to participants in the control condition with a large between-group post-intervention effect size.

However, a key limitation of this and the other studies is that they failed to compare the effectiveness and acceptability of MBCT self-help with CBT self-help for depression. This means that it is not clear if MBCT self-help has anything to offer over and above CBT self-help. It is this limitation that this study aims to address.

Research questions

This internal pilot randomised controlled trial (RCT) is a small version of the larger planned trial and will investigate:

- 1) The difference between guided self-help cognitive behaviour therapy (CBT) and guided self-help mindfulness-based cognitive therapy (MBCT) for people experiencing sub-threshold, mild or moderate symptoms of depression on measures of depression symptom severity and on a measure of intervention adherence (effect size).
- 2) How easily we can recruit to the study
- 3) How many people drop out of each intervention

We will use this information for a sample size calculation and recruitment strategy for a fully powered randomised controlled trial of the same design. If the effect sizes are in favour of the MBCT self-help intervention then funding for the full trial will be sought.

Method

Participants

We will recruit forty adults referred to Health in Mind (the primary care mental health service in East Sussex) and experiencing sub-threshold, mild or moderate symptoms of depression. Half of these will be invited to take part in a guided CBT self-help course, and the other half will be invited to take part in a guided MBCT self-help course. See Figure 1 for details.

Measures

The following measures will be taken by a research assistant blind to group allocation before the start of the intervention (baseline), immediately following the end of the intervention (post-intervention), and again six months after the intervention has ended (follow-up):

1. Patient Health Questionnaire (PHQ-9 – measure of depressive symptom severity)
2. The Short Warwick-Edinburgh Mental Well-Being Scale
3. The Five-Facet Mindfulness Questionnaire - Short Form
4. The Self-Compassion Scale-Short Form
5. The General Self-efficacy Scale
6. Elliott's Change Interview (at post-intervention only)
7. Intervention adherence

Interventions

Both interventions will use a book as a guide. The MBCT book (Williams & Penman, 2011) is based on the MBCT course and guides readers through mindfulness principles with an accompanying CD of mindfulness practices. The CBT book (Williams, 2013) is routinely used by primary care mental health services and has good evidence for effectiveness (Williams et al 2013). Participants will be guided through their allocated book over ten weeks via four phone support sessions from a Psychological Wellbeing Practitioner (PWP).

Figure 1. Randomisation of participants to the two interventions

```

graph TD
    A[Service users referred to Health in Mind meeting criteria for sub-threshold, mild or moderate symptoms of depression  
n = 40] --> B[Guided self-help mindfulness-based cognitive therapy intervention  
n = 20]
    A --> C[Guided self-help cognitive behavioural therapy intervention  
n = 20]
  
```

Procedure

The pilot RCT will recruit from three sites in East Sussex: Havens and High Weald, Eastbourne, and Hastings and Rother.

The procedure is as follows:

1. Baseline assessments will be completed by a research assistant.
2. Following completion of baseline assessments, participants will be randomly allocated by a statistician independent to the research team using block randomisation to receive either CBT or MBCT guided self-help.
3. Participants will receive either the 10 week guided MBCT self-help intervention or the 10-week guided CBT self-help intervention.
4. Participants will receive four phone calls with the PWP over the intervention period (once every 2-3 weeks) to offer guidance and support.
5. Participants will be asked to complete a weekly diary throughout the intervention in order to record their adherence to their allocated intervention.
6. Post-group and six-month follow-up assessments will be conducted by a research assistant who is blind to group allocation.
7. The study is running throughout 2014.

Chief Investigator: Dr Clara Strauss^{ab}
Research Team: Dr Kate Cavanagh^c, Dr Fergal Jones^{ac}, Billie Lever-Taylor^c, Laura Lea^c, Puffin O'Hanlon^c, Katie Gulliver^c, Liz Davies^c, Sarah Jane Franks^c.

^aSussex Partnership NHS Foundation Trust
^bUniversity of Sussex, ^cUniversity of Surrey

Study Sponsor: Sussex Partnership NHS Foundation Trust
 This study is funded through a grant awarded through the Sussex Partnership NHS Foundation Trust own-account competition.

www.sussexpartnership.nhs.uk

Figure 13: SPFT Research poster for *Low Intensity Guided Help Through Mindfulness*

study (SPFT library 2014c)

SPFT is one of the four mindfulness and training centres; the others being Oxford, Exeter and Bangor, who are each part of the *Mindfulness Initiative* along with the Mental Health Foundation. Sussex, Bangor and Exeter all have roughly the same number of publications (20 and 19), and Oxford has 76. The Oxford Mindfulness Centre was the first to be established, and Mark Williams its founder was one of those who adapted the package of MBCT from Kabat-Zinn's MBSR (Segal et al 2012), which may account for these figures⁵⁷ (see Appendix 9 for further detail on each centre). The need for creative cooperation for successful and innovative research is evident in Exeter and Bangor having gained funding for the multi-million pound nationwide National Institute for Health Research study on MBI implementation (Rycroft-Malone et al 2014)⁵⁸. The need for cooperation is also recognised within SPFT, with the screenshot in Figure 14 below from the SPFT website showing the Trust's current research and development partnerships (Sussex Partnership Research 2015):

57 Both Sussex and Oxford carry out fewer mindfulness studies in partnership with the other centres, whereas Exeter and Bangor have an established collaborative partnership. This may be because of the productive working relationship between Rebecca Crane at Bangor and Willem Kuyken at Exeter.

58 In terms of collaboration between SPFT and national research bodies, two members of the SMC were given a grant to hold a Clinical Research Group (CRG) '*Mindfulness based interventions in primary health care*' as part of the national Mental Health Research Network (MHRN). The aim of the CRGs being to gather collaborators with the purpose of identifying key research priorities within specific topic and develop funding proposals through the NIHR.

We work with our academic partners to help train the mental healthcare professionals of the future. We also continue to improve the care and treatment we provide to patients by putting research into practice.

We are now the most active mental health research organisation in the south of England. Our high-quality studies attract an increasing number of participants and are supported by the National Institute for Health Research (NIHR). We have created the Sussex Mindfulness Centre and the Centre for Dementia Studies to ensure that the learning from our research is translated into better care for patients.

Our research network gives the people who use our services the opportunity to be actively involved in mental health research and we aim to ensure this opportunity is available to all patients, carers and staff.

We have won a national award from the Health Service Journal for the clinical impact of our research and the way we involve people in our work through our seminar programme, research magazine and research network.

Our research and development partners

- Brighton and Sussex Medical School
- University of Sussex
- Brighton University
- National Institute for Health Research (NIHR)
- Mental Health Research Network (MHRN)
- Research Design Service
- Dementias and Neurodegenerative Disease Research Network (DeNDRoN)

Figure 14: Screenshot from SPFT website showing the Trust's research and development partnerships (Sussex Partnership Trust Research 2015).

The collaborative relationship between the University of Sussex and SPFT demonstrates how a strong working relationship can lie behind a successful MBI service.

As well as facilitating evidence for the efficacy of MBIs, SPFT presents itself as an employer with particular values and way of relating to its staff through organisational commitments and staff support. The Trust developed and adopted its own *Better by Experience* commitments in 2010 (one set for staff and one for patients). Its five underlying commitments are;

- *We welcome you*
- *We work with you*
- *We hear you*
- *We are hopeful for you*
- *We are helpful* (Sussex Partnership 2015).

These are key statements about the values of SPFT, with the statements '*We hear you*' and '*We are hopeful for you*' in particularly reflecting the desire to take the user voice seriously through the emotion of hope. The programme aims to focus on the experience of all who use and deliver services, through the implementation of organisational commitments relating to staff behaviour and attitude and culture within the Trust. Staff and patient national surveys commissioned by the Care Quality Commission (CQC) have indicated ongoing areas for improvement in both of these areas (Sussex Partnership 2015). I have not got data on how the programme has been experienced/received by staff or patients. SPFT have also started '*Compassion Circle*' training sessions run through Frameworks 4 Change, aiming to offer a safe, reflective space for dialogue to up to 12 people to build up personal and organisational resilience and well-being⁵⁹ (Sussex Partnership Compassion Circles 2015). This work is still in an exploratory stage and is being evaluated. Although compassion is not explicitly taught in most forms of MBI, mindfulness and compassion can be mutually enhancing, and the SMC is planning to explore research into possible clinical and organisational implications for compassion in the NHS in terms of both compassion-oriented work, and in developing a measure of compassion for others. This focus by the SMC itself evidences the links drawn between mindfulness and compassionate service delivery.

Mindfulness drop-ins and day retreats are held at multiple SPFT sites free of charge, with separate groups for either anyone who has both completed an eight-week MBCT or MBSR course and who is either a current or ex-service user, or staff groups for those who are current employees of SPFT as part of the Trust's staff wellbeing strategy (Sussex Partnership 2015). According to NHS Manager Kath, in the primary care service in East Sussex people are being referred for a specific mindfulness course, or following assessment are being offered it as a potential intervention to be followed up (and paid for) by the patient themselves. The implications of the latter in terms of access will be discussed further in Chapter 7. See Appendix 10 for details on information given to clinicians on the referral criteria through *Health in Mind*.

SPFT-funded Mindfulness teacher Janet felt very lucky to have her dedicated funded post develop from 1 to 4 days a week, and now to be running 10-11 8-week courses a

59 This training supports outcomes of the *Compassion in Practice- Two Years on* (2014) report, which recommended that 'attention needs to be paid to the foundations of a functional team; to find ways to stay connected with each other; to develop effective methods for creative problem solving, and to be able to air alternate views safely; to stay connected to the patient; to review progress and to provide the means for safe challenge and mutual support' (NHS England 2015).

year. Referrals were constantly coming in and all courses were full⁶⁰. Mindfulness is thus a 'thing' in the sense of SPFT as an institution being able to lay claims to 'do' it through both its research and accredited mindfulness teacher training programme considered in Section 3.3 below⁶¹. The Trust promotes the importance of training in signposting people to private mindfulness courses but also recommends that they look carefully at individual's qualifications. In terms of the provision of MBIs across the county, the map in Appendix 11 shows the provision across Sussex and within Brighton & Hove⁶².

This chapter now explores the impact that a culture within the Trust that is open to innovation and takes a strategic approach to MBI implementation - both through its research streams and its staff wellbeing strategies – has had on informant data on the popularity of MBIs.

▪ 3.1.1 Supportive climate

An overwhelming 95% (193) of survey respondents said that they saw MBIs as popular and as a focus for enthusiasm within the Trust. Diverse reasons were given for this popularity (chosen from a given set of choices). '*Publication of research of efficacy of MBCT*' was the most common answer⁶³ (11%), which may demonstrate the impact of the exponential growth of publications and discussions of these publications at SPFT events in terms of persuading clinicians of MBIs effectiveness (though this argument is still based on a small number of respondents). Interestingly, only 2% of respondents attributed the popularity of MBIs to the fact that they fitted with current NHS reforms. This may have reflected a desire within SPFT to affect the direction of NHS reforms through the promotion of MBIs, or of members of managerial, clinical, and training staff

60 Since 2010, SPFT CAMHS staff and Brighton & Hove Council have also been in partnership to develop, deliver and evaluate an adapted seven-week MBCT course for young people aged between 14-18 who are dealing with stress, anxiety and depression (Sussex Partnership CAMHS 2015).

61 Indeed, the SPFT website specifies that;

'Potential participants looking for MBCT groups in the community (i.e. outside the NHS) can search for local teachers on bemindful.co.uk where those advertising need to complete certain minimum standards in training and experience. Anyone seeking a MBCT group should also still assure themselves that the person teaching the group meets the national good practice guidelines' (Sussex Partnership 2015).

62 Provision of MBCT courses for SPFT staff is done through a specific training program, which is not shown on the map. This map is not exhaustive.

63 These responses however were based on a small number of respondents.

being supportive of this innovation over the past two decades (see Section 6 on opinion leaders).

Exhibiting both clinical and cultural influences, the view of one respondent was that the current popularity of MBIs was *'partly a desire and movement to understand the regulation of emotions better, partly the influence of Eastern philosophy over decades'*. Another (free-text) comment from a Mental Health nurse stated that their; *'client group and other practitioners are keen to develop and explore techniques which can be integrated into everyday life to enable increased observation, presence and awareness both physically, mentally and emotionally as part of general holistic approach to wellbeing'*. Another saw caring for their own minds as a precondition for mental health professionals to be able to properly look after others⁶⁴, with corresponding implications for staff to attend to their own mental health as part of their role and responsibilities.

Clinical psychologist Matthew tried to start each day with a brief mindfulness exercise, and felt that on an ongoing basis it certainly helped with stress at work; *'you can get lost in, in, in these kinds of jobs in the NHS, and mindfulness kind of helps you come back to yourself a little bit (.) and there's a phrase that comes back to me a lot, which is about 'giving yourself back to yourself' and I think that phrase has stuck, really'*. Clinical psychologist Tilly also stated that:

I think its a really useful tool to have, I guess that's, you wouldn't use the word tool, but I kind of um, I use mindfulness um, quite regularly, I don't always do the practices but I, I absolutely use it probably every day of my life in my clinical work, you know taking, you know, taking a breathing space, noticing where I'm at (.), and that's probably more important when you're working in a really stressful service, being able to take a, em a meta-perspective on what's going on in the room, what's going on internally, um, what sort of thoughts are popping into my mind its just, I find that so so valuable.

MBIs as a tool for coping with a stressful work environment, as well as everyday life, was commonly seen as a strength of this innovation. Related to this sense of the everyday, community course participant Mark saw MBIs as popular because of a 'first aid' element, implying an immediate relief from difficulty using knowledge available to all. Exercises could be practiced in a broader sense over entire days, but also within a

64 The link between physicians' wellbeing and the quality of care provided to patients is a current policy concern and was supported by a Department of Health Factsheet which stated that; 'individual physicians, their peers, their patients, employing organisations and the health care system must appreciate and support physicians in their efforts to protect and maintain their personal wellbeing' (2014).

timeframe of hour or twenty minutes; *'and so I think there's, you know, it's got a neat little kind of (.) promise to it (.), um, which I think, you know, that's how I think it's gaining some sort of purchase with the general public'.*

In terms of MBIs gaining purchase with the general public, 34% of respondents answered that *'Visibility – normalised as an approach'* was the main reason for their current popularity. Along with this normalisation, promotion of the evidence base through SPFT, the impact of the ongoing funding of the teacher training programme, the interest in mindfulness and 'holistic health' from particular sections of the community in Brighton & Hove, and number of Buddhist centres were also highlighted. Brighton & Hove is atypical in both demographic terms, and in the number of therapeutic options available (Dale & Letchfield 2000; Hall et al 2009). According to clinical psychologist Brandan:

I think Brighton is an area as well that, not, not that the Trust just covers Brighton but, er, there's a number of Buddhist centres in Brighton I think there's an, an interest in, I don't know if it would be seen as alternative now, but it might be seen as, you know, alternative approaches, or, or Eastern approaches and things (.), so, if you like there's also a community, er in the community there's a presence of an interest in mindfulness, that offer mindfulness and stuff so (.), in some ways it feels relatively rich.

Following a consideration of the supportive climate created by SPFT for the MBI innovation, the latest application of this intervention is now explored in detail.

○ 3.2 Latest application of innovation

Some examples were given above of the kinds of research being pursued within the Trust in order to expand the evidence base for MBIs. These included formal controlled trials, among which was a trial looking at MBIs for people suffering from distressing voices, the *'Mindfulness for Voices'* (M4V) RCT - recently completed through the SMC. Figure 15 below shows the research poster showing the M4V study, which began in 2013:

Group Mindfulness-Based Therapy for distressing voices: Increasing the availability of CBT for people experiencing psychosis

Background

Individual Cognitive Behaviour Therapy for Psychosis (CBTp) is recommended by NICE for the treatment of schizophrenia and schizoaffective disorder. Despite this, implementation of CBTp is poor, with fewer than 10% of service users with psychosis being offered the therapy. A possible solution to poor implementation might be to offer CBTp in groups, rather than individually.

CBTp offered in groups appears to be similarly effective to individual CBTp, with significant medium effect sizes (Hedges g) of 0.39 and 0.42 on positive symptoms, respectively (Wykes et al., 2008). However, as the methodological rigour of the studies of group CBTp increases, the effect on positive symptoms reduces. If CBTp were to be offered in groups, refinements are necessary to increase effectiveness.

A first refinement concerns the diverse range of symptoms associated with psychosis and the possible benefit of targeting individual symptoms. Auditory hallucinations ('hearing voices') are experienced by approximately 70% of people with a diagnosis of schizophrenia (Thomas et al., 2007) and voices are often experienced as highly distressing and disturbing (Birchwood & Chadwick, 1997).

A second therapy refinement is the integration of mindfulness - defined as a state of consciousness characterised by a non-judgemental and accepting awareness of present-moment experiences. Mindfulness-based interventions are typically delivered in a group format and there is emerging evidence for their potential in treating psychosis (Khouri et al., 2013).

Person-Based Cognitive Therapy (PBCT; Chadwick, 2006) combines a traditional CBTp focus on beliefs about voices with mindfulness practice and principles and a strong experiential focus on negative and positive experiences of the self. An uncontrolled trial of group PBCT for distressing voices found significant pre-post improvements with a medium effect size on measures of global distress and disturbance and a large effect size on voice-distress (Darnahy et al., 2011). A robust evaluation of these findings within a randomised controlled study is now required.

Methods

Study design

This was a single blind, pragmatic randomised controlled trial comparing group PBCT plus TAU (gPBCT) with TAU alone (gTAU). The primary hypothesis stated that PBCT in comparison to TAU will lead to significant reductions in distress and disturbance in response to hearing voices. The Brighton and Sussex Research Ethics Committee (number 11/L0/1330) provided ethics approval for the study.

Measures

Blinded assessments were completed at baseline, 4 months and 10 months.

Primary Outcome

Clinical outcomes in routine evaluation-outcome measure (CORE-OM) - a 34-item scale of distress and disturbance (Evans et al., 2000).

Secondary Outcomes

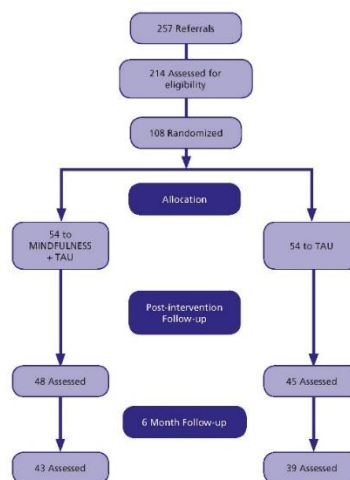
PSYRATS: Auditory Hallucinations Scale (AHS) - an 11-item rating scale measuring the severity of different dimensions of the voice-hearing experience (Haddock et al., 1999).

Hospital Anxiety and Depression Scale (HADS) - the HADS is a 14 item measure of anxiety and depression (Zigmond and Snaith, 1983).

Choice of outcome in CBT for psychosis (CHOICE) - CHOICE is a 2-dimensional 24-item self-report CBT for psychosis outcome questionnaire providing scores for severity and satisfaction (Greenwood et al (2010).

Results

Figure 1: Flow of participants through the study.



Intervention

PBCT groups were conducted over 12 one and a half hour sessions. Each group was led by two experienced therapists.

Sessions 1 and 2:

- Hopes and concerns about coming to the group
- Establish ground rules
- Exploring onset, impact and meaning of voices
- Mindfulness practice and reflection

Session 3:

- ABC model of voice hearing (Chadwick et al, 1996)
- Mindfulness practice and reflection, linking to ABC model

Sessions 4-6:

- Explore relationship with voices, drawing on ABC model
- Gather and review evidence to support beliefs about personal control in relation to voices
- Mindfulness Practice

Sessions 7-10:

- Gather and review evidence to support positive beliefs about self
- Set and monitor progress towards valued goals
- Mindfulness practice

Sessions 11-12:

- Review learning and progress
- Identify next steps for learning and how this will be supported

Sample characteristics

108 participants were recruited from secondary mental healthcare services in Sussex and Hampshire (50% male; age range 18-65 years; 91% White British; 76% unemployed). All participants had a diagnosis of Schizophrenia or Schizoaffective disorder. Baseline characteristics between the two study arms were similar.

Outcomes

Data analysis is currently in progress and a paper will be submitted for publication in a peer reviewed journal in July 2015. Preliminary analysis shows that, relative to TAU, PBCT was not different at post-intervention or six-month follow-up on the primary outcome measure (CORE). However, PBCT did show significant benefits over TAU at post-intervention on secondary measures of distress (HADS depression, PSYRATS intensity of distress) and disturbance (CHOICE, PSYRATS voice control), although only effects on depression were maintained at follow-up.

Discussion

The effectiveness of PBCT groups for distressing voices was evaluated within a RCT. Relative to TAU, PBCT participants did not report significant improvements on the primary outcome measure of distress and disturbance. However, PBCT participants did report significant reductions relative to TAU on measures of distress (depression, intensity of voice-distress) and disturbance (voice-control, recovery) - with the significant effect on depression maintained at six months (but lost on other measures).

There were seven hours of therapist contact per therapy completer within group PBCT (the total number of therapist hours divided by the number of patients who attended eight or more sessions) - as opposed to the sixteen hours recommended by NICE for individual CBTp. This reduced therapist time would allow more patients to be treated with the same therapist resource, thus partially addressing the accessibility issue.

The effect sizes within this study are similar to the effect sizes from trials of individual CBTp for distressing voices. This suggests that group PBCT may not be inferior to individual CBTp in treating distressing voices. However, this current trial was not powered to test this non-inferiority hypothesis and this is the research question for our next study.

Investigators

Paul Chadwick - Institute of Psychiatry
Mark Hayward - Sussex Partnership NHS Foundation Trust & University of Sussex
Gara Strauss - Sussex Partnership NHS Foundation Trust & University of Sussex
Anna-Marie Jones - Sussex Partnership NHS Foundation Trust & University of Brighton
David Kingdon - University of Southampton

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Figure 15: Research poster of the M4V study (SPFT library 2014b)

The screenshot in Figure 16 below also shows part of the page devoted to the M4V trial in a [2015] edition of the Research Magazine of SPFT which showcased recent innovative research (Sussex Partnership Research Magazine 2015) (the significance of the title '*Taking Part in Research*' to be explored further in Chapter 7);

Taking Part in Research

Mindfulness for Voices (M4V)

A total of 108 patients distressed by hearing voices from both Sussex and Hampshire completed the M4V study. Half were assigned to the control group and the other half assigned to the therapy group which combined CBT with brief mindfulness practices.

Seven of these therapy groups were run across the two counties. Follow-ups were then completed after six months in order to determine if the effects of mindfulness training were long-lasting.



Thank you for taking part

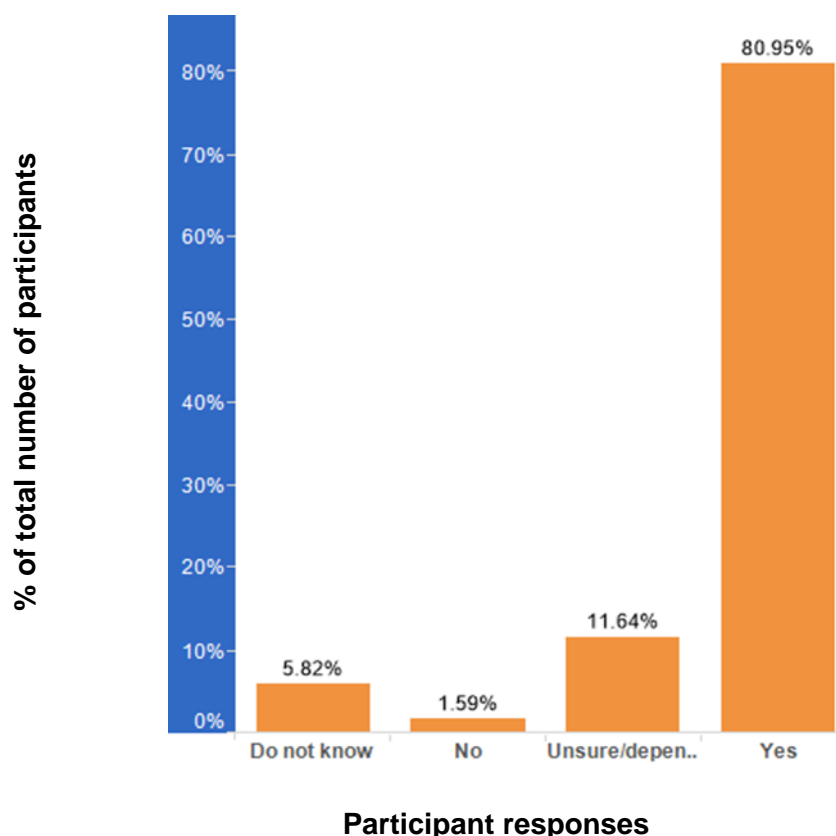
The Mindfulness therapy for people who hear distressing voices (M4V) study has now finished. The results are being analysed and key findings will be made available to participants and clinicians in 2015.

We would like to thank our participants for taking part. We would also like to thank our clinical teams in Brighton, Eastbourne, Hastings and Worthing for their hard work in supporting the study.

Figure 16: M4V trial text in Research Magazine of SPFT (Sussex Partnership Research Magazine 2015).

The clinical team running M4V did not find significant improvements in the Phase 2 stage for the group receiving the MBCT against the core primary outcomes of psychological health (self-esteem, anxiety, depression and levels of mindfulness). The control group in fact *improved* and there was greater frequency of voice hearing for the experimental group. There were however unanticipated therapeutic benefits of being in a group, and data evidencing a reduction in depression (which could aid motivation towards social and personal recovery goals). It is planned that groups will be held for this patient group in the voices clinic in Brighton & Hove and Eastbourne. This decision was informed by the findings from the trial and would not have been rolled out in this way if the team had felt the groups were not effective, despite the lack of significance of data for the primary outcomes of the trial. This study was not carried out at a time when these results were public knowledge, yet all GP survey respondents had heard of the M4V trial which it was ongoing. This perhaps could reflect the fact that it was carried out in Sussex, the visibility of the work of particular academics such as Paul Chadwick dominating previous work in this area (2000, 2002, 2008), and that M4V was the first large RCT with an exclusive focus on mindfulness for the treatment of voices.

Turning from awareness to perspectives on the utility of mindfulness as a treatment for distressing voices, Graph 3 below shows the percentage of clinicians from the online survey who saw MBIs as suitable for people experiencing distressing voices, even as the trial was ongoing, based on the survey completed in 2014.

Graph 3: Are MBIs suitable for people experiencing psychosis?

What was significant from this data was that staff informants already thought they knew the answer to this question of the utility of mindfulness for distressing voices. MBI's application to psychosis seemed to already have been embedded into the mentality of those responding to the survey, resulting from the trial being already in progress as well as Chadwick's involvement. As many as 80% of respondents believed MBIs to be useful for people experiencing distressing voices, and the free text data suggested nuanced levels of uncertainty and reservations. Many respondents wanted to wait until the outcomes of the trial before stating their position in confidence on the efficacy of mindfulness for distressing voices, and felt nervous about recommending mindfulness as a main intervention for this condition. Non-clinical participants did not feel qualified to comment on the efficacy of mindfulness for psychosis, but offered thoughts on the potential effects of MBIs on the relationship of an individual with their voices.

Data also highlighted that the importance of the elements of trust and group safety apply across a *range* of talking therapies (including MBIs), and that attitudes of non-judgmental acceptance towards what is happening in the present could extend to people with psychosis. Mindfulness teacher Izzie also spoke of applying practices that

had helped her personally through very difficult emotional times in the past as a mechanism:

I: Do you believe that mindfulness interventions might be helpful for people experiencing distressing voices?

P: I believe yes. But yeah I'm not a clinical psychologist (.) but (.) yeah I have heard from other people that the whole practice of observing the mind (.) with a degree of distance, observing rather than being caught up in it, and the practice of coming away from thoughts and back to the body (.), means that these voices become less distressing. You know I mean we all have thoughts, and whether you call them voices or not we all have distressing thoughts, pretty much I would say. (.) And learning to just not take them seriously, not believe it, yeah, (.) I mean I can speak personally, I mean I know I don't have to, but I've had some very difficult times emotionally in the past, and this is what's got me through.

The implications of the results of this trial for future MBI service provision is considered further in Chapter 7. Having explored the position of SPFT as creating a supportive environment for the creation of evidence, this chapter now turns to the position of the Trust as a trainer of staff to facilitate mindfulness groups of their own.

○ 3.3 The Trust as knowledge facilitator

The SMC Mindfulness teacher training programme is funded mostly through the Education and Training department of SPFT and has been running since 2011. It is open to NHS staff who have completed the 8 week MBCT/MBSR course as a participant, have a regular mindfulness practice, and can envisage ways in which they could run MBCT groups after completion of the training (Sussex Mindfulness Centre 2015). The programme uses an apprenticeship approach with a strong emphasis on supervised MBCT group facilitation, theory, regular feedback on teaching practice, and daily mindfulness practice.

SPFT Mindfulness teacher and Clinical Psychologist Adam commented that the popularity of the training had grown to extent that the team had to pull the last advert early because of demand; *'the momentum is quite extraordinary actually, like we've, we've been commissioned to run another five staff groups next year [2014] and er, so that's a capacity of 50 people, 10 in each group...in a way-, we're mobilising something much bigger than us'*⁶⁵.

⁶⁵ This is in the context of SPFT employing 3383 staff (not all of them with a referral capacity to mental health services), as well as members of external Trusts that attended the programme.


The first intake had 18 trainees, with a mean age of 43 years (SD=7 years). All were mental health professionals, with the places of twelve trainees funded by the SPFT, and six from a nearby Trust who bought in the training (Marx et al 2013). A second intake had 18 trainees, 6 who were staff employed and subsidised by the SPFT, and 12 working in other NHS organisations, independently in private practice, or working in the community or charitable fields (ibid). The 2013 intake had 7 SPFT staff and 11 community or non-SPFT NHS staff. This was the first in-house program of its kind in the UK, one which has evolved to provide training to external individuals. In this way the Trust may be hoping to expand the provision of this training (the one year intensive training costs £4,900), and buy-in may increasingly become a way of spreading mindfulness expertise and best-practice to other Trusts.

Rather than trialing the outsourcing of this intervention SPFT has been keeping MBCT training mainly in-house, with Sussex becoming the second place after Bangor with recognised teacher training in MBIs, a program explored in this section. SPFT's overall turnover is set to reduce over the next two years from £240.3million in 2013/14 to £231.3million in 2014/15, and £227.4million expected by 2015/16 (Sussex Partnership Operational Plan 2015). The training program may have found space within the logic of the Trust partially through its capacity as a source of training revenue from other Trusts, though this is also a means to keep the program going⁶⁶. The MBI staff training programme was also evidence of the Trust moving ahead without RCT evidence for conditions beyond recurrent depression.

The screenshot in Figure 17 below shows the online promotional material for the SMC training program. Significant in this screenshot is the fourth bullet point which states that Sussex Partnership applicants for Trust funding for the training need to work in a service in which there is some evidence of the efficacy of MBIs for that population, or 'where there are clear proposals' from the Research and Development department 'to work on innovative approaches within that population'. This statement demonstrates the equal emphasis made on the areas of focus of the R&D department (some of whom are members of the SMC) as on evidence generated from elsewhere. In this way

66 The stated desire to deliver 'essential training in the most effective time and cost efficient way...There will be a review of the methods of delivery of essential training. We will find the optimum combination of e-learning modules, web ex and classroom based sessions whilst recognising the benefits of staff engagement in face to face learning sessions and managing the delivery of service' (Sussex Partnership Operational Plan 2015: 34).

training is a marshaling of an intervention understood as innovation, and carries optimism for the future.

 Print this page

Mindfulness training

We offer a one year Foundation training in Mindfulness-based approaches (MBCT/MBSR).

The training is open to people who have completed the 8 week MBCT/MBSR course as a participant, have a regular mindfulness practice (including practices taught on the MBCT/MBSR courses), and can envisage and describe ways in which they could run MBCT groups after completion of the training.

Sussex Partnership applicants applying for Trust funding need to:

- have a professional mental health training
- have the support of their manager and clinical lead to take the necessary time to do the training
- work in a role which would allow for the delivery of the 8 week MBCT course
- work in a service where there is some evidence that the populations using that service can benefit from MBCT, or where there are clear proposals from the Trust Research dept to work on innovative approaches with that population
- work in an area and service where there is currently minimal provision of MBCT and/or where there are strategic Trust objectives for extending the delivery of MBCT.

The training uses an apprenticeship approach with a strong emphasis on supervised MBCT group facilitation, resting on a firm foundation of theory, regular feedback on teaching practice and daily personal mindfulness practice.

The training model we use has been described in greater detail in the following publication: Marx, R., Strauss, C., Williamson, C. (2014). Mindfulness apprenticeships: a new model of NHS-based MBCT teacher-training. *Mindfulness*, DOI: 10.1007/s12671-013-0254-2.

Figure 17: Screenshot of online promotional material for the SMC training program: (Sussex Mindfulness Centre 2015).

The rationale for training healthcare staff has been made by several studies that have attempted to evidence ongoing patient benefit⁶⁷ (Shapiro et al 2005; Aggs & Bambling 2010; Khoury et al 2013; see also Byron et al 2014 on mental health setting implementation; Smith on MBSR for work-related stress 2014; and review and meta-analysis of interventions by Regehr et al 2014). Evidence has suggested that, perhaps unsurprisingly, clinician burnout can negatively affect patient care⁶⁸ (Krasner et al 2009;

⁶⁷ Ludwig & Kabat-Zinn argue that, at least implicitly, mindfulness has always been part of good medical practice in terms of helping to facilitate a compassionate approach to patient care (2008). Epstein has suggested that 'mindfulness is integral to the professional competence of physicians' in the reduction of medical errors and aiding of clinical decision making (2008: 1351).

⁶⁸ In a recent article Luchterhand et al described a programme to promote mindful awareness for clinicians, trainees, staff, and patients (2015). To provide excellent patient-centered care, he

Beach et al 2013; Fortney et al 2013). From an 'insider' perspective Brandon also noted the potential impact of attendance on MBI training courses on staff awareness of their own stress levels and dissatisfaction with their workplace environment *increasing* rather than becoming more manageable:

It could be that actually, as you practice more mindfulness, what you might see is that you might see that your work environment is quite toxic (.), or not good for your mental health, and you might want to make some changes in life (.).

Although the majority of the staff who attended may have felt better able to deal with difficulties in their working lives as a result of attending an MBI, the potential for the light of the awareness brought to be shone onto more negative aspects was also present. If this impact became widespread it may decrease the motivation of the Trust to invest in the training. Related to this position Wolkowitz argued that how far the 'holism' promoted by CAM practitioners is 'actually realised in embodied interactions, rather than remaining at the level of discourse, is influenced by conditions of employment, including especially the managerial philosophies, staffing policies and payment systems that have evolved in the context of custom and practice of different occupations' (2002: 503). This argument reinforces the central role of embodied experience in contributing to the emotional climate in which MBIs are being delivered, and the role of MBIs in facilitating this experience.

Integrally related to the process of gaining funded and accreditation for the staff training programme, key individuals within SPFT can be identified who lie behind the momentum of this innovation, champions and opinion leaders.

- **4. Role and influence of embedded individuals**

- **4.1 Champions and opinion leaders**

Individuals can be identified within SPFT who take a particular approach to knowledge transfer of the evidence base behind MBIs, and experiential knowledge of mindfulness practice. It is possible to evaluate these approaches in terms of the likelihood of clinicians to refer and the benefits of their experiential knowledge.

argued that clinicians and staff must be fully present, flexible, and recognize their own patterns and beliefs, and that these qualities are engendered by sustained mindfulness practice (ibid).

Champions play a strategic role in supporting an innovation within a particular social network and representing it to external stakeholders. These individuals include high profile mindfulness teachers, academics and psychiatrists⁶⁹. The crucial role of champions was also supported by a recent implementation study by Crane and Kuyken (2013).

In the context of Sussex, experience from other Trusts suggested that early stages of MBI implementation rely heavily on a local champion with strategic influence and MBI training to steer the process of change, and sustainability through patient advocates, referrers, and MBCT therapists (Crane & Kuyken 2013). MBI participant Daniel for example discussed his efforts to incorporate mindfulness practices into his workplace (a secondary school):

I'm trying to build that in to um, staff meeting as well, you know, some members of staff are a little (.), but they're getting used to it. And, having that vision, you know, from the Head and from other people, and in, in a community which is a Christian community but in which many people are not Christian, but nonetheless is a community which says 'there is a, a yearning in people to stop and be still, and quiet and reflect', I think does, help to support, those endeavors.

In terms of the mobilisation of resources, funding for a further five years was also gained for the staff training programme, which was championed by particular individuals from the outset (Sibthorpe et al 2005; Hendy & Barlow 2012). These same individuals were also opinion leaders (see below).

On a team level, a range of stakeholders commented that SPFT's stated values and organisational commitments to wellbeing could also be maintained by the incorporation of MBIs into clinical practice. Clinical psychologist and mindfulness teacher Adam highlighted that those who are trained then need to be strategically embedded within SPFT teams:

I think having people who are trained embedded within teams widely will, you know, enable those people to offer drop-ins to staff, you know, so other staff can try it and, you know, they can explain what suitable referrals would look like and um, you know potentially there's a lot more we could do about spreading

69 Beyond Sussex the involvement of psychiatrists in the field of mindfulness in the past has been mainly limited to occasional support on personal blogs and websites, mainly in the US and Australia and New Zealand (Mindful Psychiatry 2012), but in recent years this has changed, with public figures such as Felicia Huppert, Fellow of the British Psychological Society (also from New Zealand), becoming actively involved in mindfulness RCTs (Khouri et al 2013).

information about what's available and how it's effective with all kinds of clinicians and GPs.

The statement 'MBIs are popular' was as common in the data as 'MBIs have a strong evidence base', in part because of the institutional base of support this intervention had within SPFT (Rimé 2007). Relating to Adam's comment in Section 3.2 regarding the mobilisation of something bigger through the SMC training programme, it was felt by some participants that an alternative micro-culture was created within a team when a manager or members of that team had an ongoing mindfulness practice and embodied particular qualities⁷⁰. When SPFT Team manager Neil was asked whether attending an MBI had affected his team his comments evidenced the effect of this embodied role-modelling on the relationships between its members (with Neil in this sense occupying a position as a champion of this intervention):

Sure, I, I mean there's been quite significant changes going on in the North West Sussex I mean with the ATC [Assessment Treatment Centre] model being implemented and, we've had drastic short-staffing um, and performance has been low (.), and so being able to sort of manage a team (.) when you're sort of up against it with sort of low morale, low staff numbers (.), and actually keeping it reasonably fresh and supportive, it, it, rather than just sort of the normal "oh we need to get this done by such and such" and sort of deadlines all the time (.), I think its helped (.) maintain a sense of um, cohesiveness with the team really, and I think its that role-modelling of that approach, that new perspective of looking at things, its helped and enabled me to support people but also lead by example.

GP Margaret showed a degree of self-consciousness and reflexivity (also linked to aspirational motivation through peers to increase attendance of MBIs), when she explicitly mentioned the innovation literature and the role of 'champions' as a starting point for an implementation strategy:

The innovation literature all says 'go for the early innovator champions and then go for the next level' (.), you've got to go for people whom the other GPs respect, keep looking up, saying 'I could be like that I could be like that', until the last lot say 'oh well I might as well'. So, yes I think its a good way in.

As the adoption of mindfulness practices by NHS managers and team leaders demonstrates, developing a mindful relationship with one's body and emotions also does not preclude (and indeed may help) active engagement with society⁷¹ (Brown

⁷⁰ This data supported recommendations by the NHS report *Compassion in Practice- Two Years on* (2014) (England NHS 2015) which stated that the manager/leader plays a pivotal role in connecting teams and individuals to their core purpose within an organisation.

⁷¹ Buddhism, the source of much of the teaching of mindfulness, is by its nature engaged, evidenced through movements such as Socially Engaged Buddhism (a term that Thich Nhat Hanh also popularized in his writing) and the work of the Buddhist Peace Fellowship (BPF)

1992).

This chapter turns now to the role of opinion leaders embedded within the Trust who have a particular influence on their colleagues. Previous literature has supported the necessity of opinion leaders but a central concern has been the difficulty in pin-pointing a description of opinion leaders, as understandings of their roles are subjective and also differ between settings⁷² (Arndt 1967; Locock et al 2001; Watts & Dodds 2007). For the purposes of this study opinion leaders are defined as those embedded within the networks of an organisation who wield a recognised influence and act as a source of advice to their colleagues and peers.

In line with previous literature on this subject, MBI opinion leaders identified within Sussex carried information across social boundaries between different stakeholder groups (Burt 1999). Opinion leaders' influence was also reliant on levels of trust and social capital amongst their professional peers⁷³ (Brown & Michael 2003; Flodgren et al 2011). An outline of some of the key opinion leaders within SPFT is given below (all information from public record).

Eight key figures can be identified within SPFT: three academic, three practice-focused (these individuals qualified at Bangor, some who taught mindfulness nationally as well as in Sussex), and two whose roles were prominently managerial and without whom MBCT for patients nor the staff training programme would have been commissioned. Many of the opinion leaders were clinical psychologists, and acted as a particular group within this profession that wanted to further incorporate mindfulness into the health service as a possible tool. Some had both clinical *and* academic roles (illustrating the importance of collaboration and relationship between SPFT and the University of Sussex), using both clinical and academic evidence together for legitimacy. The majority were members of SMC, and the remainder were everyday clinicians who gained extra authority through involvement with the MBI innovation but were also

(Queen 2000). Engaged Buddhism can provide an emphasis in practice which is appealing to Westerners but should not be seen as a new form of Buddhism but as having a particular emphasis (ibid).

72 Credibility and influential authority derive from personality, interpersonal skills and dynamics, as well as from other context-specific factors.

73 Nuances of the collective organisational basis within which opinion leaders function have been considered in the sociology of expectations literature, which will be explored in the following chapter.

familiar with the day-to-day experience of clinicians⁷⁴. Despite publicity at SPFT conferences, events and staff research newsletters, 54% of survey respondents had *not* heard of SMC, though all GPs respondents *were* aware of the centre as a strategic gathering of both clinical and non-clinical specialists for research output, training coordination, and evidence and information dissemination⁷⁵.

A core of individuals all shared a commitment to making MBIs part of the interventions available within the health service. Each had come to MBIs through different pathways, some had a long-standing interest in Buddhism and meditation, others had dipped into mindfulness practice as a means of managing stress and difficulties arising in their everyday life. These individuals occupied particular positions within SPFT and created particular resources for themselves, as well as having an in-depth knowledge of the Trust's organisational restrictions. All narrated their interest in MBIs with reference to the evidence base for this intervention, as well as how the practice had helped them personally. There were of course other opinion leaders who could have been identified beyond SPFT regarding their influence within Sussex that there was not scope in this study to explore.

In terms of this influence, only 1% of respondents said that they got information relevant to their practice through '*Team Meetings*' (perhaps a reflection of the priorities of these forums). In terms of the dissemination of information; 58% of people had heard of the MBI they attended from a colleague, and this perhaps reflected the growth in visibility of mindfulness in the Trust. The majority of the rest was split between the '*Internet*' (16%) and '*Other*' (23%). This demonstrated awareness of MBIs being spread through professional networks (Sibthorpe et al 2005; Borup et al 2006), and peer opinion leaders, and the transfer of information through personal contact (McGettigan et al 2001).

In terms of where clinician respondents to the survey felt they got, or were most likely to get, information relevant to their practice, the most common response was '*From peers one a one-to-one or adhoc basis*' (36%). '*Email updates*' (18%) and '*Research*

74 Locock et al differentiated between 'expert' and 'peer' opinion leaders (whose influence could differ at different stages in the innovation process), with 'expert by experience' and 'peers' being terms that apply to these individuals in Sussex (2001: 745).

75 In a UK wide survey of over 200 GPs carried out for a 2010 report by the Mental Health Foundation, fewer than one in 20 GPs (4%) considered themselves very well-informed about MBCT (27% said they are quite well-informed about it, 47% say they are not very well informed, and 22% had never heard of it) Halliwell 2013: 27)

'Magazine' (13%) (see Figure 18 below which shows a selection of the SPFT Research Magazines referred to in this survey) were the following most common responses.



Figure 18: Selection of SPFT research magazines (SPFT library 2015)

Opinion leaders existed at different levels such as at the managerial level and on a peer-to-peer level among clinical colleagues. The number of informants that got their information from colleagues indicated the need for well-networked, if not high profile, embedded individuals (Locock et al 2001; Greenhalgh et al 2004; Valente & Pumpuang 2007). Reflecting the value of peer-to-peer recommendations, when asked about her view of the use of technology, Mental health manager Sue's view was that people would be more likely to make use of online or electronic devices if they '*already knew someone who had experience with it, so it might build on something that their friends were using, I expect there would be a personal relationship somewhere in the history*'. Clinical psychologist and mindfulness teacher Adam discussed the value of peer recommendation and word of mouth:

That's kind of just happening culturally and, you know, nationally and so on, and internationally. Um, so we're riding this big wave, I think, and hopefully trying to channel it a little bit, and within our organisation, so I, I could see (.), you know, and I think, I think generally people enjoy doing the groups, so I think the more people do the groups the more they'll talk to their friends and their colleagues and say 'maybe you should try this', so I, I potentially could see it expanding and the culture maybe becoming more pervasive within the Trust, um, and, you know I think in terms of the patients there's a real need for the research evidence to be more embedded, particularly in the NICE guidelines, I think that would make a really big difference.

The value placed on the experience and advice of peers hinted at the emotional (rather than purely rational) basis for knowledge transfer and the role opinion leaders can be argued to have in terms of the creation of an emotional climate within teams (De Rivera 1992; Vacharkulksemsuk et al 2011).

▪ 4.1.1 Emotional climate

According to De Rivera, an emotional climate is an 'objective group phenomenon that can be palpably sensed' (1992: 2). It was later defined as 'the predominant collective emotions generated through the social interaction of a group's members in a particular milieu' (Rivera & Paez 2007: 235). Rivera and Paez also professed that little remained known about this area⁷⁶ (see suggestions in Chapter 8 for directions for future research) (2007).

In terms of wider organisational culture, clinical psychologist Adam commented that a central collation of evidence through the SMC evaluation pack allowed for the demonstration of the impact of MBIs on staff as well as on the culture of a team or organisation. The role of clinical leaders as catalysts of cultural change within their organisation has been the subject of recent studies such as Luchterhand et al (2015). These impacts were evidenced on an anecdotal basis through a '*kind of sensitivity and appreciation*' felt through the collective presence of staff '*that is a bit different from what you feel generally as you go about your day (.) down the corridors of the Trust*' (Adam), in particular those who keep up the practices and attend the follow-up sessions.

One response from the online survey also stated '*we're quite blessed...in a community where there's a presence of an interest in mindfulness*', indicating an interest in a specific area of participatory medicine that reflected the surrounding culture (see Tran 1998 on emotional climates in interactive systems; Gyani et al 2014). The fact that MBIs are being delivered increasingly in non-clinical settings has increased the need to move away from the paradigm of the 'medical model' towards a broader multi-agency

⁷⁶ Rivera's later work with Paez argued that; 'although such climates are socially constructed and perceived by individuals, they are objective in the sense that they are perceived as existing apart from an individual's personal feelings. They reflect how individuals think the majority of others are feeling in the group's current situation' (2007: 234). Implied through the term 'climate' was an interest in emotional phenomena in relation to underlying social structures, rather than more temporary moods.

approach (Edwards et al 2014). Relating to earlier discussion on the role of consensus building in responses to EBM (Fairhurst & Huby 1998), Barbalet's work in particular argued for the critical role of emotions within this process as the 'experience of involvement' (2002: 1). MBIs thus appear to play a role in breaking down cultural barriers within an institution and between that institution and the wider community.

Not all of the data however supported MBIs role in the creation of an emotional climate within SPFT. Speciality doctor Becca felt that attending would have no real impact on her team:

Yes, but I was thinking 'if I go for them, first of all I have to take time off, and then what? It's not going to be enough for me to use it for myself, you know, personally, and its not going to have any bearing on what is happening in my team, you know, on Chalk Hill. So you know, its going to be something really interesting and pleasant and you know, quite, quite interesting, but there's not going to be any finality from it.

Drug & Alcohol worker Stef also did not feel that anyone else on her team was particularly interested in it or that it was a feature of the way that team worked. Counter arguments to the creation of an emotional climate were useful in highlighting the importance of economic and organisational constraints on the adoption of MBIs.

A central strategy used by both champions and opinion leaders - and also one that fitted with diffusion of innovations literature (Valente 1995; Greenhalgh et al 2005) - was employing and promoting experiential knowledge of mindfulness. The SMC brought the roles of opinion leaders and champions together.

○ **4.2 Experiential knowledge**

Part of the role of opinion leaders within SPFT lay in passing on the benefits of mindfulness practice and generating a different kind of evidence, that of embodied experience and practical knowledge (Leonard & Sensiper 1998). Dopson used health policy-makers' use of the principles of EBM in aiming to change clinical practice, to explore the introduction of innovation and processes of managing complex change (2005). Freeman and Sweeney argued that processes of implementation were 'complex, fluid and adaptive', and that it was not possible to identify a single main factor that 'causes' the adoption of new clinical approaches (2001). The case of MBIs in Sussex fitted Fairhurst and Huby's model of 'consensus and reinforcement' best in terms of a consensus over the credibility of MBIs through NICE, then reinforced

through the strategy of particular opinion leaders (1998). Supporters of the MBI intervention saw NICE as a particular source of epistemic authority but also drew on personal embodied experiential knowledge. Mindfulness teacher Chris stated that *'you have to have, I believe, your own practice and your own, um, (.) yeah your own practice and your own experience to be able to know how to help other people do that'*.

A staged strategy could thus be identified. This started with the promotion of the endorsement of MBCT by NICE, followed by the embodied experience of mindfulness practice used to spread awareness of the therapy. The opinion leader literature focused more on personal influence, rather than on evidence or NICE guidelines changing day-to-day practice (Fairhurst & Huby 1998; Dopson et al 2008).

In Armstrong & Ogden's study the patient was identified as a key means of updating GPs on changing clinical practice. Some GPs stated that 'they learned from their patients', and that the the outcomes of others' clinical practice had the most influence on their own (2006). This form of experimentation on individual or series of patients produced 'evidence' in a different form to the formal procedures of EBM (see Armstrong 1995, 2006; Armstrong & Ogden 2006). Based on the number of 'successes' among their peers, GPs in this study then incorporated the treatment into their own practice. Data from this study also demonstrated a different form of 'learning' along with evidence from guidelines, as in the case of GP Margaret, who was using self-experimentation of the MBI practices that had helped her to inform her referral decisions. Matthew also highlighted the role of embodied knowledge, reinforcing the relatively unique position occupied by MBIs in being subject to self-experimentation – the shift from *using* to *doing* – rather than following the experimentation pathways identified by Armstrong and Ogden⁷⁷ (2006):

But (.) um (.) if you're going to do something to somebody, if you're going to preach about something then, then you have to be using that in your own practice, and that's the same for anything really, you know, a CBT approach, if you're not using CBT with yourself if you're not able to analyse you-, y-, your kind of own thoughts (.) then you're going to be a poorer position for kind of

77 Following from my position taken on emotion in the previous chapter, these individuals are not blind to emotions but use them in a strategic way. In some cases the impact of their embodied knowledge of mindfulness led to the facilitation of mass mindfulness exercises at Trust conferences and other public events, spreading awareness of MBIs through embodied experience. The extent to which these individuals can be counted as opinion leaders may be due to people looking up to them as individuals who embody mindful qualities as well as this attention being due to research effects.

marketing that approach to somebody else, getting them on board with it (.), its the same with the mindfulness approach I think.

Related to discussions within the literature on factors that contribute to patient benefit, Gale has highlighted the need within CAM for practitioners to understand their own embodiment within their therapeutic relationships (2011). Data on MBIs being subject to self-experimentation can also challenge the dualist conception of the central dynamic in the therapeutic encounter being 'the mind of the doctor working upon the body of the patient' (ibid: 246). The assumption at the heart of this notion being that the the body of the doctor and mind of the patient loses significance.

Building on data in Chapter 5 regarding the effects of mindfulness practice, the promotion of MBIs to staff within SPFT and how they narrate their participation will now be considered in more detail.

- **5. Stress and wellbeing at work**

SPFT staff could participate in MBIs to train as a trainer through the SMC programme (explored earlier in Section 3.3) or to address their own stress and wellbeing levels (or both, these reasons not being mutually exclusive). In terms of reasons behind staff participation in MBIs, different responses could be identified; from stress, to references to the MBI evidence-base as a reason for participation or hope for ongoing benefit to their patients. 40% of clinician survey respondents had previously been on an MBI course. From those survey respondents who *had* attended an MBI, the comparatively low numbers of survey respondents answering '*To feel happier and more content*' (12%) compared to stress (25%) as their reason for attendance may have reflected a difference in legitimacy of the different reasons rather than fewer people in actuality *wanting* to feel happier.

Stress and anxiety are the most significant reasons for NHS staff sickness absence, with work-related stress is estimated to cost more than £30 billion annually, and hidden costs on top of this estimated to be much higher (APPG 2015). In terms of stress reduction policies within SPFT, the Trust adopted a staff Health and Wellbeing strategy (H&WB) in response to NICE guidelines on public health in the workplace (Sussex Partnership Health and Wellbeing Strategy 2015). The Trust also provides a Critical Incident Psychological Support service (CIPS), committed to addressing '*the causes as well as the symptoms of stress and therefore work with the organisation on issues*

relating to work place wellbeing and stress management' (ibid). Despite the CIPS however, the data suggested there may be more perceived stigma or seeming self-indulgence involved in having the 'luxury' to primarily attend a course in an effort to be happier. A diagnosis of stress was not required to legitimise staff attendance on an MBI, but was used by many staff respondents to describe their experience and motivation for attending. Stress can thus be seen a quasi-clinical category in making sense of a clinical intervention (Ernst & White 2000; Barcan 2011).


Figure 19 below shows a screenshot from the SPFT website below illustrates the difference in language used in information for patients about MBCT (Sussex Partnership Mindfulness Based Cognitive Therapy 2015). Stress was part of the Trust's narrative as an acceptable means of the promotion of MBIs to its employees and those from other Trusts (see arrow below), primarily through signposting staff to recent research for the efficacy of MBIs for stress.

What problems can mindfulness-based cognitive therapy (MBCT) help with?

Many people find that worrying about the future or ruminating over past events can leave them feeling more anxious, stressed or low. Often this worry and rumination can feel very difficult to control. It may continue despite our best efforts to stop it.

MBCT can help us learn ways to reduce worry and rumination, which can increase our mental wellbeing. MBCT works by strengthening our ability:

1. to notice unhelpful thoughts
2. to let these thoughts go
3. to relate to ourselves with greater gentleness and kindness.

There is good evidence that MBCT can help people who have suffered from three or more previous episodes of depression. There is growing evidence that it can help other problems too, including chronic pain, anxiety and stress. 

Our NHS Trust offers a range of other therapies and course. Sometimes one of these may be more helpful than MBCT in the first instance. Also, for some people, now may not be the right time to start MBCT. For example, if you have a current drug/alcohol problem or have experienced a recent bereavement or trauma then it is probably best not to start MBCT at the moment.

Figure 19: Screenshot from SPFT website setting out the benefits of MBCT (Sussex Partnership Mindfulness Based Cognitive Therapy 2015).

Another screenshot shown in Figure 20 below then shows promotional materials and a list of mindfulness groups available for SPFT staff (Sussex Partnership Mindfulness Based Cognitive Therapy 2015). Ten different groups are run over eight different locations across the county, with various starting times and days throughout the year.

Mindfulness groups for Sussex Partnership staff

As well as groups for service users, we provide groups for staff as part of our staff wellbeing strategy. Groups for 2015 are available to be booked. Bookings will be taken on a first come first served basis except for staff who flag up particular support needs who will be prioritised. Read about what is involved in a staff mindfulness group [here](#).

[Download an application form](#) - please complete and return to smc@sussexpartnership.nhs.uk. See below table of staff groups for 2015.

	Location	Dates and times	Group leader
1	East Brighton Community Mental Health Centre, Brighton General Hospital, ground floor group room 1	Tuesdays 3.30 to 5.30pm 20 October to 15 December 2015 (no session on the week of 4 November) Please note there is a day retreat on 5 December 2015	Robert Marx
2	East Brighton Community Mental Health Centre, Brighton General Hospital, group room CR2	Thursdays 3.30 to 5pm 16 April orientation then 8 weeks from 30 April to 18 June	Taravajra

Figure 20: Promotional information for Mindfulness groups for SPFT staff (Sussex Partnership Mindfulness Training 2015)

Reasons given in the interviews for attending MBIs can be categorised into two clusters, the first identifying attendance as being primarily for personal use. Speciality doctor Becca said that she had an anxious-type personality and thought mindfulness would help to manage the ruminations. MBI participant Teresa was interested in meditation as a way of being calmer and more even-handed in her outlook on life, and had found those outcomes were then reflected in the course she attended, and mindfulness teacher Simon had had severe chronic fatigue for about ten years and was practicing as a Buddhist when he had an opportunity of participating in a mindfulness course his friends were running.

The second cluster revolved around direct involvement with SPFT. Clinical Psychologist trainee Tilly had initially felt resistant to some of the language and ideas used (she discussed this resistance as an interesting by-product of attending). It was only after doing the practice over time that Tilly's thinking fundamentally shifted, through embodied experience that moved in a different direction from her perceptions of the fluffy language that she'd previously thought was being used. Tilly then went on to facilitate mindfulness courses for people with chronic pain and those with learning disabilities. For SPFT Team manager Neil his MBI was recommended by his line manager to support his management skills and help carry the day-to-day stresses of his role.

This chapter now considers the success of the approach taken by opinion leaders and champions in terms of levels of awareness of MBIs as a therapeutic option, levels of course take-up and referral behavior.

- **6. Clinical implementation**

- **6.1 Awareness**

This section of the chapter explores the 'currency' of MBIs and the relationship between doing a course and its clinical use. Mindfulness training in the context of Sussex often means the British version, as this was the MBI with visibility within SPFT (MBSR being Kabat-Zinn's original course in the USA). MBCT and MBSR are very similar, and both originally designed to help with specific mental and physical health conditions. MBCT was a combination of most of the MBSR syllabus with some cognitive therapy exercises. More emphasis is made in MBSR on understanding the mechanisms like lie behind stress for the general population, and in MBCT on clarifying the mechanisms underlying depression.

94% of clinicians responding to the survey had previously been aware of MBCT compared to 53% aware of MBSR. This is perhaps because the majority of courses being run in the UK follow the MBCT format established by the team at Oxford (Teasdale et al 1995, 2000). This visibility may also have been due to Sussex being one of four 'centres' of mindfulness in the UK, the number of trained teachers, funded studies, and the interests of the particular demographic in the area around Brighton & Hove.

In terms of workplace variation, single-handed practices had particularly low levels of awareness of MBCT (26%), but among groups with low awareness of the original form (MBSR) (e.g. single handed practice GPs) there was still some awareness of MBCT. It was clear that awareness of MBCT was far higher across all workplaces than of MBSR (see Graph 4 in Appendix 13). This evidences the dominance of the use of MBCT as compared to MBSR within the Trust, through the interrelated factors of MBCT following CBT and this being the area with the largest body of evidence (indicating the continuing importance of this evidence base)⁷⁸.

In terms of how community MBI course participants became both aware of, and receptive to, this therapy in their personal lives, several informants discussed chance encounters with promotional materials that acted as a prompt for action building on previous experience and value-base. Mental health manager Sue commented on the need for MBIs to be on people's previous sphere of experience in order to be accepted:

Mm, its interesting isn't it, it does seem to be very much the thing of the moment, I guess there are sort of ways in which it mentions...relationship with familiar things helps to get something (.) accepted pretty widely...Um, so yeah as I said before I think people need to have some way of understanding, having a sort of conceptual understanding of what they already know and understand (.), for something to become of interest or something to explore.

Experiential knowledge from other parts of an individual's life indeed meant that some respondents were receptive to MBIs, and that it was not just SPFT endorsement or input that led people into contact with mindfulness⁷⁹. Some form of contact with meditation practice was indeed mentioned by many participants as a background to their interest in attending an MBI (Elliot 2007). Clinical psychologist trainee Phillip was also aware his previous interest in mindfulness through Buddhist practice had led to a different feeling from his colleagues within the Trust⁸⁰:

Er, I became interested in it from a spiritual point of view about 8 years ago (.), I went to the Western Buddhist Centre and attended two courses, and read books and so on, so it wasn't from an NHS intervention approach at all (.), so that feels quite different to colleagues of mine who have interest in it.

78 These figures can usefully be compared to the survey of GPs carried out by the MHF, which concluded first that 'GPs are generally very positive towards mindfulness as a health intervention', with nearly three-quarters (72%) believing 'learning mindfulness meditation skills would be useful for their patients with mental health problems', and almost as many (68%) thinking 'it would be helpful for their patients in general' (Halliwell 2010: 27). Most of the rest did not know if MBIs would be helpful, and 'very few GPs who are aware of Mindfulness courses are hostile to them' (ibid: 27).

79 Indeed, an individual could be an SPFT employee and still not pick up on the presence of MBIs if they had not had them in their previous sphere of experience.

80 However those with a direct link to Buddhism were the minority within my sample.

Levels of awareness of MBIs could be distinguished between *out* of SPFT (with mindfulness existing as a strong theme in popular culture) and *within* the Trust, where MBIs were being implemented but with assistance from currents from the wider culture. In terms of this link, the discursive repertoires discussed above can be used to consider expanding the demographic of users of this intervention within the health service in Sussex.

○ 6.2 Increasing Access

Relating to previous arguments on the dissemination of innovation through experiential knowledge, the targeting of specific sections of the population will now be considered. A free text response in the survey argued that *'MBIs should be taught to all practitioners in the mental health profession, so they can appreciate for themselves the benefits and get a better understanding of how it could prove helpful to their service users'*.

Following from data on referral patterns and the dissemination of evidence within Sussex, part of broadening the demographic of MBI users would also require more referrals to be made by GPs to MBIs. GP Eleanor benefited from attending an MBI on multiple levels, and having found an MBI provider, had been trying to identify patients whom she thought might benefit. Getting GPs and clinicians to go on courses themselves could thus be seen as a promotional strategy on the part of the Trust, though in terms of the direction of change for MBI endorsement and funding for new services, NHS manager Kath made it clear from her position that GPs as commissioners were not the ones leading the initiation of further provision of courses.

Opportunities have been limited for professionals to develop mindfulness-based skills, and MBI expansion requires increasing access to introductory and teacher-training courses for clinicians who are interested (suitable teachers have so far been mostly self-selecting), as well as identifying and training suitable course leaders (MHF 2010). Advice from within SMC also suggested that the electronic folder for supervision groups on the MBI staff training course through SPFT could be built on and developed (Marx et al 2013). As recommended by GP Jim, MBIs could also be introduced during the early training of all doctors as well as potentially being part of ongoing CPD⁸¹.

81 Key recommendations by the MHF Report on Mindfulness (2010) included that; *Mindfulness-based approaches should be taught during the early training of all doctors and offered as part of their continuing professional development. Few patients with*

Clinical psychologist Adam said *'more GPs should know about it, because they're community practitioners and it is a community, it's very much a community-based sort of treatment, if you want to call it a treatment'*.

Both community MBI participants and clinical psychologists within the Trust raised the strategy of getting managers to attend courses. Clinical psychologist Adam, a key member of the SMC, discussed the *'whisperings of rolling it out more systematically to managers so that it infiltrates a bit more of the culture at the top um, which would be good'*. Adam went on to attribute the popularity of MBIs within Sussex Partnership to a lot of the Directors and the Chief Executive being particularly supportive of it as an innovation, which supported the opinion leader study in Chapter 5⁸². MBI participant Teresa also stated:

I think that anybody you're dealing with in a senior role, get them to do it. Get them to do it for themselves and experience it for themselves, because you know, I was about to say at the end of one Board meeting when it came up as an agenda item 'You lot should all do it, every one of you', and then I thought 'this is not the way to win friends and influence people', but if I can try and pick off one or two at a time, and talk about the benefits, and, you know there is an evidence base, and it's not all, you know, that sort of thing, erm, so, if you can get people to (.), er, experience it personally...And I think that's the way (.), it's sort of 'critical mass' really.

Mindfulness teacher and Clinical Psychologist Adam argued that *'the more managers that actually do it and feel the benefit themselves, the more that will spread. I mean for example there's a manager in, in Chichester who has done the course themselves and knows for themselves the benefit of it and really promotes their staff to you know, have drop-ins and you know, lunch-time meditations and things like that (.)'*.

Mindfulness teacher Simon presented the argument that there was no need for specific targeting in terms of adapted MBIs for different groups:

To do a course, it's like, you know, I mean, if you were to say, 'alright we want to train healthcare professionals to do mindfulness' you would give them pretty

recurrent depression who might benefit are currently being offered Mindfulness interventions. It is particularly important for GPs to increase their understanding of the potential benefits of MBCT for these patients, and to know what services are available locally. Opportunities for professionals to develop Mindfulness-based skills are limited. There should be more opportunities for clinicians to train as Mindfulness teachers and practitioners themselves (Halliwell 2010: 31).

82 At no point in the data with stakeholders from staff working within SPFT was ill-feeling or scepticism on the part of managers explicitly mentioned. The focus was more on the need to garner their support.

much the same course, I mean maybe you wouldn't give the one that's, you wouldn't give them MBCT targeted at depression, but it would be the same sorts of practices, the same process. We all have the same basic stuff going on, you know, mindfulness doesn't, you don't imbibe it by learning the principles from the theoretical level, you learn with your direct experience, which, you know, is just the raw stuff of being a human being, so, that's the only way to learn it, you know, ultimately.

Emphasising the shared humanity of participants as a key part of a mindfulness course does not negate the efficacy of adapting some of the exercises for the benefit of particular groups.

The following section explores in more detail the specific impact that attending an MBI had in terms of referrals made by clinicians to a mindfulness course.

○ 6.3 Referral behaviour

Armstrong and Ogden asked 'which knowledge – and how – is accumulated and at what point knowledge accretion gives way to action, that is, when clinical behaviour is actually changed?' (2006: 952). The number of those who had referred a patient to an MBI (112: 55%) was higher than may have been studied only a few only years ago, perhaps due to the rise of availability of academic publications on the efficacy of MBIs, or the referral criteria have been widened to include depression and anxiety-related illnesses (see Appendix 10) (Crane & Kuyken 2013).

For those referring clinicians, a similar percentage (25% and 23% respectively) said they would refer to '*MBCT as a treatment for depression*' and '*MBCT as a treatment for depression and anxiety*'. These responses fit the widespread nature of these illnesses in the general population (Shapiro et al 2006; Edenfield & Saeed 2012). From those who *had* referred, '*MBCT for other issues*' was the most common answer given (37%). As expected there was only a small number of participants who would refer to an online course⁸³.

Other factors impacting referral decisions may have been due to dual diagnosis or lack of awareness of the comparative benefit of availability of MBSR or hybrid courses in the community. Armstrong & Ogden's study argued that there were two mechanisms

⁸³ The choices given to respondents were based on the most common conditions for which MBIs are currently used), and the coding frame included those responses that stated a number of different difficulties that the patient had.

through which GPs changed their decisions without compromising their (much-defended) clinical autonomy, etiquette (meaning the often implicit rules influencing behavior and the acceptance of advice on protocol) and clinical experimentation (2006). The latter is of more relevance to this study, though clinical etiquette is present in the degree to which a clinician shares their own experiences with a patient (see quote from Margaret below). MBIs offer a particular form of self-experimentation that clinicians then incorporate into their referral repertoire.

GP Margaret:

I: I was going to say how much you use your own personal experience in terms of your practice and what you recommend?

P: I just don't know, well there are papers as you know which talk about um, doctors revealing that they've had a particular disease that they're dealing with their patients with. And um, I think the jury's out, it depends how they do it (.), if they then spend the whole consultation talking about themselves...! I don't think it's very effective. And also there's all this stigma with depression I always find it slightly difficult to know whether they'll stop thinking I'm cogent if I tell them I've experienced depression. It's not straightforward. But I think that the, the evidence with depression is that people will feel less stigmatised if they're being treated by somebody who seems to have survived. So-.

GP Margaret's comment was also interesting in terms of the role of embodied experience in treatment-related decisions, and highlighted the difficulties in the use of embodied knowledge as well as evidence of clinical etiquette.

Despite the prevalence of CAM in the UK, little is known about GPs beliefs, though evidence suggests they continue to see a role for forms of CAM within clinical practice (Jarvis et al 2015). This positive belief however is not always matched in daily practice, and the majority of GPs (69%) in Halliwell's online survey of 250 GPs (representative of the UK population in terms of gender, region and age) rarely or never referred patients to MBCT courses, with only one in 20 (5%) referring patients very often⁸⁴ (2010). According to NHS manager Kath there were some GPs who would categorise MBIs as a complementary therapy and might identify a patient that they think would benefit, but she questioned whether a future scenario would look like a patient going to their GP and saying you know, '*Actually doctor, I'd really like to do mindfulness, where can you refer me?*'. Kath's view was that in reality if an individual went to their GP and said '*I've been reading about mindfulness, you know, I read a really good article in a magazine*

⁸⁴ This may be because of the availability of courses: only one in five (20%) GPs in the MHF survey said they had access to them. GPs also stated that they needed other means of treating recurrent depression: three-quarters (75%) prescribed their patients antidepressants despite having the view that other approaches may be more appropriate for their patients (Halliwell 2010).

about mindfulness, I think it's something I could really benefit from', that the patient would probably be signposted to a Third Sector organisation or a clinic down the road, or yoga centre where they could pay for it themselves. This also puts the onus for action onto the service users being referred. There was a narrow margin between the 47% survey respondents who said they would know which provider to refer to and the 53% that said they would not⁸⁵. More significant was the scale of the number who said that they had no service to refer their patients to.

A crosstabulation using SPSS showed a strong correlation between whether a clinician had been on an MBI and whether they had ever referred a patient to one (though 50 respondents had *not* been on a course and yet *had* previously referred). GP Eleanor said she probably would not have identified these patients if she had not herself attended the course. These responses were highly specific to the time the interviews took place, and the varying length of time since respondents had attended the MBI. Attendees may also have felt under pressure to say they would have referred because they had attended a course. However non-MBI attendees were also generally very positive about their likelihood to refer in future, with 97% stating that they would consider it. If clinicians responding to the survey had *not* previously referred a patient to an MBI course, the majority *would* then consider referring in the future with some reservations⁸⁶. These figures suggested a degree of optimism and hope to be explored further in Chapter 7, as well as allowing space for the role of champions and opinion leaders⁸⁷.

Despite these figures, experiential knowledge was commented on by many participants such as community MBI attendee Mark:

85 People who said they would know which provider they would refer also knew this because they had already referred.

86 Only 2 respondents said that they would not consider referring in the future, having not done so up to the point the survey was carried out.

87 When asked if they knew which service they would refer to, the majority of respondents already knew of a provider, with only 3 saying they were unsure, or commented that NHS courses were few in number. For those that did not know where to refer to, some knew the individuals they could contact for this information. Others commented on the lack of availability of psychological therapies in the NHS, but commented that in the local area there are also courses available at reasonable price. This may be evidence of a degree of willingness and hope ahead of service provision (Damschroder et al 2009). The need for more information on which to base referral decisions was a common response. Respondents here were working within institutional parameters of knowledge of available services to refer to and available information about their quality (data suggested this was largely drawn from peers on an ad hoc basis).

I: Do you think personal experience would affect referral patterns of GPs?

P: Absolutely, yeah, for sure, because I think it provides GPs with, you know, a real deeper understanding of who it would benefit and what those kind of benefits would be. As opposed to, then it just becomes like another drug they get to read about (.) where they get to say 'well I've just read this and apparently it's quite good, why don't you give it a go'. Whereas most GPs I know, and there's one in our band actually, could do with it (.), they're pretty stressed out pretty busy people.

This position was also supported by SPFT mental health manager Kath:

Yeah, I think, we see that in a whole range of referrals, you know, um, if someone's experienced something, or they understand it, or they've had a series of patients who've benefitted from it talking about the benefits to them, and I think that's -, 'cause I suspect GPs would come from a position of being more sceptical about this.

Whether the impact of clinician attendance on MBIs on referral patterns was part of a formal SPFT strategy was difficult to specify. The Trust may have incorporated interventions based on their recognition of the importance of experience and personal practice, and the data suggested that this was recognised by the survey respondents.

The majority of respondents had heard that mindfulness courses were also available online but were reticent to refer their patients to these courses, possibly because of existing skepticism about online CBT through the IAPT programme (Thomas et al 2013). In terms of recommending Emotion-focused Cognitive Behavioral Therapy (ECBT) to patients, GP Emma identified difficulties in motivation in attending an MBI, which patients *have* to feel that it is the right thing for them:

Yeah, I, I think, I mean, certainly with things like CBT we can recommend 'ECBT' to our patients, but I think the difficulty is, um, you have to be motivated, you have to feel that its the right thing for you, um so I think-, I don't know how other people feel about mindfulness, but I, you know I think some people maybe will put up a bit of a barrier and think 'I don't need this', that kind of area...Because I think if you really feel its not for your you'll probably get nothing out of it, although you'd have technically done it, you know, done the course.

The data developed Armstrong & Ogden's study on the impact of patient experience on prescribing and referral patterns (2006), and revealed a degree of self-consciousness about these processes, asking a broader question than '*do clinicians refer to MBIs?*'. Unlike Armstrong's theory of the role of clinical experience, the data suggested 'experiential knowledge' as a term which needs to be taken seriously (2006). Clinical

psychologist Matthew's comments on practitioner use of mindfulness also illustrated the value of alternative forms of knowledge:

I think in some ways you're probably, those practitioners that use mindfulness best are those that, have come to it in and of itself, and use it in and of itself (.), which is, controversial I guess, because MBCT is developing quite an evidence base for itself, um, it would be interesting to see, kind of mindfulness versus MBCT in way, to be controversial.

In terms of what influences the selection of patients to refer to an MBI, 'Ability to reflect/concentrate/commit to whole course' (31%) and 'Patient choice/interest/motivation' (22%) were the two most common clinician responses to this free-text question in the survey. 'If patient is in crisis/suicidal/substance misusing/self-harm' and 'Accessibility/Ability to travel to venue' were the following most common responses, reflecting the more practical concerns over the suitability of mindfulness to someone who is either physically or mentally unable to get to or cope with the course. Also highly important were the reputation of the teacher and course, and recommendations from trusted colleagues.

Information for referrers on the SPFT website largely reflected the study data, it mentions stress as a potential condition to be treated, and that MBIs will not always be the first treatment option recommended, and upon what conditions an appropriate referral depends (see the screenshot in Figure 21 below (2014)).

Referers: who can benefit from mindfulness-based cognitive therapy (MBCT)?

If you are thinking MBCT may be helpful for someone you are planning to refer to our services, please bear in mind that service-users/patients will usually receive a generic initial assessment that will consider a range of treatment options. Where possible, we aim to offer service-users choice from a selection of potentially helpful interventions.

Mindfulness-based cognitive therapy (MBCT) is recommended by NICE guidelines as a prophylactic intervention for adults who are currently well but have experienced three or more previous episodes of depression. There is also growing evidence that it can be helpful for some people who have a history of depression and are currently depressed, though this may depend on whether they have sufficient concentration and motivation to be able to participate.

There is also an increasing body of evidence that MBCT, or variants of it, can be helpful for a range of other conditions including stress, chronic pain and certain anxiety disorders.

Some of our children's services are taking a lead on developing and evaluating mindfulness-based interventions for children and adolescents.

Beyond this there are likely to be individual reasons why MBCT may or may not be currently suitable for a particular individual. For example, MBCT is less likely to be appropriate for someone with current substance misuse problems or recent/unresolved psychological trauma or bereavement.

Sometimes there may be other interventions that are likely to be as helpful or more helpful than MBCT in the first instance. In such circumstances, service-users/patients may be offered the option of attending an MBCT course after they have completed the intervention that was thought to be initially more helpful.

Figure 21: SPFT website information for referrers to MBIs (Sussex Partnership Mindfulness Practice: Information for Referrers 2015)

The data suggested that recommendation or referral to an MBI is not enough to guarantee either attendance or longer-term benefits of mindfulness practice. In terms of influencing behaviour beyond the implementation of clinical guidelines a key issue therefore appeared to be how to frame and present MBIs to those who do not have this therapy on their previous sphere of reference, and in what ways the value of MBIs can best be demonstrated to different user groups.

Integral to discussions of expanding access to MBIs are varied factors affecting the dynamics of implementation.

- 7. Dynamics of implementation**

The nationwide *Accessibility and Implementation in UK services of an effective Depression Relapse Prevention Programme* (ASPIRE) study that began in 2014 investigated the extent of the implementation of MBCT in the health service to date and

the underlying factors behind this (see Appendix 14 for this study protocol). The results of the feasibility pilot highlighted the limited accessibility across the UK, with 81% of respondents reporting that the implementation of MBCT had not yet started within their workplace. In organisations in which it *had* started, very few respondents to this study reported that this was occurring in a strategic and systematic way, and when this had occurred this change had been driven by ‘enthusiasts’ (champions and/or opinion leaders), though still largely lacked organisational commitment as well as integration with other services (Rycroft-Malone et al 2014).

In the literature implementation was seen as challenging, with a common focus on resistance and ‘barriers’ (these barriers being both organizational and psychological. A central sociological problem is therefore understanding how innovation happens and is imagined as both challenging and straightforward. My data helped draw attention back to practical issues in the implementation of innovation; with training provision being a key one. Sussex being at the forefront of MBI training meant that they have to plough ahead and find funding for new and existing services, while also maintaining the production of existing training courses and RCTs.

Of relevance was a comment by Chris regarding capacity, that funding decisions to divert resources cannot be made without the provision of trained staff:

Yeah, and also the capacity, you know, it's not just, anybody (.), you can't, you can't just kind of go 'Oh ok, well lets go for mindfulness and um, let's go and get, you know, so-and-so over there, who's a trained psychologist, to go and deliver mindfulness. You can't, it's not a theoretical thing.

In terms of MBIs as part of IAPT, its roll-out has been limited by a lack of trained therapists, meaning that its ambitions may not be achieved (Centre for Economic Performance's Mental Health Policy Group 2012) (Curtis 2012). According to Crane & Kuyken there can also be a ‘mismatch between the duration of time that it takes to cultivate MBCT teaching skills, and the cultural tendency within the NHS to get people trained quickly, get them delivering and then get them training and supervising others’ (2013: 250). Psychologist and MBI course participant Helen also highlighted both the necessity of a trained therapist, and the fact that the complexity of delivering it means that as a therapy it will be something that fades⁸⁸. This was contrasted with the attraction of MBIs as an intervention that still necessitates a therapist but also can (and

⁸⁸ Hence the focus in Chapter 7 on suitable forms of follow-up support.

must) be practiced individually, potentially offering a different kind of excitement and involvement. As suggested by mindfulness teacher Izzie, this befits the current agenda of self-care and self-help (Walters et al 2008) in the pursuit of wellbeing (Barker 2014):

And it's also part of empowering people for their own health (.) erm, on a different but related topic, there was some article by a cardiologist who writes in the Guardian, and he was saying, you know, 'don't just smoke and drink and eat hamburgers and expect me to suck out the crap from your arteries, its much better if you look after yourself in the first place' (.), and he was talking about a patient who was coming with this exact thing. So that kind of attitude of expecting someone else to look after your health for you is quite prevalent. And mindfulness is very much going the other way, giving people a responsibility for their own mental health, up to a point, without getting into blaming them if they don't. And and it is quite a shift, and it is a demanding course it does take a lot of time and is quite hard for some people.

The necessity of embodied mindful qualities of both the MBI facilitator and health professional trainees when they returned to practice was a recurrent theme in both the data and previous literature (Holmes 2010; Mehling et al 2011). Clinical psychologist Adam identified two levels of facilitation; what he termed the '*technique approach*' to delivering a course based on embodied mindfulness practice, and the '*deeper level*' of aspirations and motivations drawn from wider Buddhist practice that he tries to inform everything he does. Mindfulness teacher Janet made the assumption drawn from her own experience that if teachers have been on the 8-week training '*there's more of a sense of them embodying this um, um, you know, acceptance, being more in the moment (.), integrating that kind of philosophy into their work*'. This comment again relates strongly to the role of embodied knowledge and MBIs being subject to self-experimentation.

Clinical psychologist Matthew also contributed a slightly different perspective on the need for MBIs to go beyond the manualised level, as well as for the science and evidence behind it to be apparent:

I think if you're going to deliver it as an intervention you need to have a, an experiential understanding of it, I think that's a, er, necessary, for, for it really. Um (.) if you're trying to deliver mindfulness in a kind of manualised mechanistic way, um, you aren't going to get very far and your clients aren't going to get very far with it I don't think. I think it helps having a language to explain (.) science behind it, maybe (.) because people want that, people want to know why something works, and why they should invest their time in it.

Clinical psychologist Matthew did not see mindfulness and CBT as compatible, arguing that the latter's cognitive components undermined some of the principles of

mindfulness of accepting experiences and moving into more of an un-judgmental, observer position. Clinical Psychologist Brandon expressed concerns over the loss of an 'essence' and the risks involved in MBI's expansion, as well as the need to attend to causes of stress and pressure on an organisational level:

And so it, it's having a balance with that. And, also when its offered in organisations, I think there can be real value to it, but, there's a potential risk, I think, maybe in organisations, to say 'well we've offered something for our staff, these, these mindfulness courses' (.) when actually, what may be just as important or more important is attending to some of the organisational culture, or pressures and things.

For Clinical Psychologist Brandon and supervisor within the SPFT training programme, one of the main pitfalls of mindfulness was the ease at which it can be paid 'lip service' to, which he felt really diluted the importance of the intervention. Clinical psychologist Matthew expressed a similar fear in similar terms, reinforcing the necessity of experiential learning:

So, I think some Trusts and policy makers will pay lip-service to it, and probably don't understand it, actually. I think its, CBT has been around for a long long time as, as an example, commissioners, policy-makers, know, know basically what it is, you're kind telling somebody that their thoughts are faulty and they need to (laughing) change their thinking (.), um, mindfulness, you can't only learn about mindfulness from a theoretical position, it has to be an experiential learning (.) more so, than a theoretical learning, and I think that's, that's probably why policy makers might say this (.) might use mindfulness in their language, and in thinking about services, but whether they understand it as an approach (.) that'd be an interesting piece of research to do as well I guess really.

The particular problem with 'lip service' is that it is not a sustainable strategy likely to be transferred to ongoing funding, nor one likely to take user involvement into sufficient account (Jacobson & Curtis 2000).

Clinical psychologist Matthew discussed problems of quality control as not unique to MBI but as common across the NHS. He gave the example of untrained occupational therapy technicians running relaxation sessions and calling them mindfulness groups, giving mindfulness a bad name in the sense of being wrongly labelled and misunderstood, an over-reliance on hope and belief in its magically transformative potential, signifying wider risks in the popularity of this intervention⁸⁹. Privatized

⁸⁹ Dacher has argued that mindfulness training that does not progress through the later levels of meditative practice becomes an advanced relaxation technique (2014). Though relaxation

providers can also exacerbate these difficulties in terms of there being less funding set aside for evaluations/assessments. Indeed, the SPFT website specifies that:

Potential participants looking for MBCT groups in the community (i.e. outside the NHS) can search for local teachers on bemindful.co.uk where those advertising need to complete certain minimum standards in training and experience. Anyone seeking a MBCT group should also still assure themselves that the person teaching the group meets the national good practice guidelines (Sussex Partnership Mindfulness Practice 2014).

This comment was also interesting in terms of mindfulness becoming part of the language and culture of the Trust. Mental health nurse Steve made an argument that despite being interested in the scientific and clinical applications of mindfulness, the secular version of the therapy as currently applied within the health service is incomplete without being integrated into an individual's worldview and to consider the surrounding context (Grossman 2010):

There is a conflict within me because I can find everything I need within the teachings of the Buddha, and the techniques I have learned through Zen. I am not interested in techniques that are removed from that origin, because they don't seem authentic to me personally as an individual. I think I would advise anyone I knew who was having problems to look to whatever gives them strength, and mindfulness can help to enhance a focus on something helpful. But that strength has to exist within some wider structure whether it be a religion, or a philosophy, or a way of life, if it is to be effective and sustainable. So secular mindfulness is for me incomplete on its own and has to be integrated into a person's worldview to work. The worldview in itself may be flawed which will hinder the cultivation of mindfulness, but with practice perhaps the worldview can be explored and redeveloped through mindfulness.

Discussions of the risks of losing as essential 'essence' chimed with the need for a facilitator who integrates mindfulness into their worldview and embodies the same qualities they are attempting to teach. Clinical psychologist and mindfulness trainer Adam foresaw the risks of the poor quality delivery increasing the more MBIs expand, of needing to maintain a sense of a core:

Its not for example a 'commercialisable' kind of thing if you're really keeping the heart of it I don't think, so its a bit of a paradox there that some people are starting to earn quite big money out of it and um...there's going to be a tension I think...Because its really a kind of heart-felt kind of thing, and um...I think where there are other kinds of personal agendas that get in there, it, it will affect it, it will affect the effectiveness as well.

techniques can be hugely beneficial, the evidence-base supporting a specific form of mindfulness training means that this structure should be adhered to.

Brandon went on to argue that what is of real importance is that people have choice, rather than MBIs being the sole or obligatory therapeutic route⁹⁰. Concerns over dilution and loss of the key elements that make mindfulness effective, along with the difficulties in balancing the Buddhist and cognitive elements of MBCT, were also shared by GP Eleanor. Mindfulness teacher Simon raised the issue of the balance to be struck between those fearing dilution of the core content of the course, and those who may be put off by the mention of spirituality or religiosity:

I mean there's concerns either way (.), so there's, you know, many Buddhists have concerns that mindfulness will become (.), that the teeth will be taken out of it, by popularised, you know, commercialized practice. And then, you get concern by lots of people who come along to courses, and wouldn't want anything that had a tone of religiosity about it.
I: Like you said, something that is negotiated in each place perhaps?
P: Yeah, absolutely, yeah.

Indeed one of the concerns of a clinician respondent to the online survey when deciding whether or not to refer a patient to an MBI was that; *'I have no idea now what to do other than give people info on expensive courses run in the community. I struggle with this especially if there is a religious (Buddhist) undertone to the courses'*.

Clinical psychologist trainee Philip suggested that different models of service provision exist; more prescriptive services with patients directed to take up an intervention because it was found or formulated to be the suitable option, another as signposting a number of different options and information for people to use to make informed choices, of which mindfulness could be one. Philip saw more responsibility and efficacy lying in the latter model, with patients making informed choice themselves.

The challenges and concerns discussed above relate closely to the corresponding need for the 'creative' approaches specified in the study title as a defining feature of 'innovation'. Rather than applying to the *delivery* of MBIs, in this study 'creative' was applied to the approach to innovation taken within SPFT; the blend of evidence and experience, and the use of facilitator training as a specific task. Creative is a term which is also applicable to the finding and drawing on new language for value.

⁹⁰ Brandon referred to Kabat-Zinn's (2013) article that expressed similar concerns along with a cautious optimism, also acknowledging that 'whether it's a dilution or just a different way, but, say it is a dilution, that it can still be helpful'.

- **8. Conclusions: mindfulness in Sussex, the story so far**

Chapter 1 considered how NICE came to include MBCT as a treatment for recurrent depression. Endorsement by NICE created a positive feeling for MBIs, with a crucial need for empirical evidence for this intervention involving levels of training and facilitation expertise. Respondents to this study negotiated national evidence-based guidelines in interesting ways. RCTs as part of a wider strategy provide a grounding for evidence within the Trust, but this process can be expensive and crucially takes time, thus not always fitting the strict time frames of a service commissioning environment (May 2006). Data also supported the literature that clinical trial data only becomes relevant for routine practice only confirmed by other sources, and is supported by a consensus among peers (Fairhurst & Huby 1998).

MBIs are being employed strategically within SPFT; both as a research theme, through the SMC training programme, and as part of efforts towards staff wellbeing through providing courses. This strategy allows an expression of compassion within the Trust, as well as an MBI focus on prevention and targeting of children, a group that is seen to experience its own stresses and challenges. The popularity of MBCT was largely attributed in the online survey to SPFT publicity, and in people seeking ways of managing stress (and *distress*) through many means. Stress was seen as a legitimate platform of publicity on the part of the Trust, primarily for service users. A key factor behind the growth of MBIs in Sussex was through SMC's teacher training programme, which formed a key part of the strategy of forming opinion leaders' for whom experiential knowledge was a precursor of interest *in*, and practice *of*, mindfulness (Armstrong & Ogden 2006, *italics mine*). The way in which MBIs evolved within SPFT and Sussex suggested that the literature on opinion leaders and champions was still of relevance. A small group of people also act as champions for this intervention, motivated by personal commitment as well as evidence. They pursue an evidence strategy in the Trust, not only by carrying out RCTs, but also in seeking to develop experiential knowledge among staff as a way of embedding mindfulness within SPFT. The SMC helps create a defined group of champions and legitimizes reaching out through training without MBIs being immediately used in their clinical work.

The correlation between clinicians having attended an MBI course and whether they had referred a patient to one, provided a justification of the continued availability of staff training (with the assumption that increased referral rates are desirable and that staff are able attend the courses if provided). It was not necessary to have attended an MBI

in order to refer a patient to one but it helped (though there were exceptions to this). Personal experience of Buddhism and meditation were also commonly cited as part of the interest in MBIs. Attending MBIs created the opportunities for experiential knowledge through self-experimentation, rather than experimentation on small numbers of patients, and helped the spread of innovation through personal networks and peer relationships (Armstrong 1995, 2006; Greenhalgh 2005). SPFT provided MBI training for staff to then deliver therapies themselves in future, as well as staff to attend to deal with stress.

Success at speedy introduction, also lead to worries among champions who were very concerned to maintain value and integrity of MBIs. Factors influencing the implementation of MBIs raised in the data centred around: dilution; loss of essence and quality through commercialization; facilitators not embodying a mindful worldview; mindfulness being paid lip-service too, and implementation in services without due care. Notes of caution also reflected some of the mindfulness literature on the dangers of practicing *without* a parallel attendance to daily behaviour patterns (Grossman 2010; Kwee 2010).

Chapter 7 develops these issues further, considering how the future of MBIs has been imagined more broadly in terms of the agenda of valuation. It examines the contribution of the sociology of expectations in terms of its organisational and emotional aspects (Kitzinger & Williams 2005; Moreira & Palladino 2005), the challenges of managing these expectations, and the contextual factors that may affect the long-term future of this intervention.

CHAPTER 7. IMAGINED FUTURE OF MBIS

- **1. Introduction: key agendas**

This chapter addresses the final research question (p.20) exploring the implications of the mindfulness agenda for future policy and practice, both within SPFT but also at the national level. Emerging findings from this research illustrated that MBIs have a foothold in the Sussex Partnership Foundation Trust (SPFT), but that their future is uncertain. MBIs may find a place but there is a need to demonstrate some form of value. This chapter looks at different possible arguments for forms of valuation - cost being a central but not solely important one – and valuation beyond the model set out by the National Institute of Health and Care Excellence (NICE).

Value in healthcare is increasingly defined in an economic sense as the cost incurred for the achievement of a particular output (Porter 2010). Yet what things are worth can be manifold and subject to change, and values can combine, conflict, overlap, or contradict each other, with much depending on the form of valuation. In this chapter, the dominant mechanisms currently used for evaluating particular health interventions from an economic perspective are considered, as well as issues specific to evaluating MBIs.

The contested concept of valuation is then used to explore the ‘regimes of hope’ and the ‘regime of truth’, terms used by Moreira & Palladino to describe differing organisational logics (2005). In their work, the ‘regime of hope’ contained the view that improved or new treatments are in a constant state of emergence or testing, with this promise serving to justify research and development. On the other hand the ‘regime of truth’ entailed what was positively known, rather than what *could* be (ibid). According to this perspective most forms of medical treatment are less effective than claimed, involving clinical failures, ethical downfalls, and new approaches returning to their claims. The sociology of expectations literature also illuminates both the contingency of the future, and the need to balance ‘hope against hype’ in its imagining (Brown 2003).

Surrounding the future of MBIs, their potential role in the articulation of alternative values is considered in light of the concerns of values-based medicine (VBM), theories of recovery, and service users’ ‘lived experience’. As discussed in Chapter 6, the M4V trial is again used to further illustrate issues of valuation in mental health.

Another way to claim the value for MBIs is to insist that a long-term perspective be taken on the effects and value of the therapy. Strategies for maintaining both this value and cost-effectiveness of MBIs are identified in the data, not simply as a strategy of care but through an imagining of the future of this intervention as part of an integrated model of care. These discussions are set in terms of the contextual restrictions on MBI implementation, in particular the funding environment. Building on the discussion in Chapters 5 and 6, in this chapter emotions are considered to be intrinsic to attempts to imagine a future of MBIs.

- **2. Value and Valuation**

The study of valuation is, at its core, about making the social practices of valuation discussable and, possibly, thereby also accountable. It is about turning the establishment, assessment, and negotiation of values into topics for conversation (Doganova et al 2014: 88).

This statement by Doganova et al can be used as a starting point to explore the parameters of value and valuation, including issues of definition, measurement and evaluation, which 'delimits and stabilises' the object studied (ibid), and depends on what is seen as worthwhile research and its outcomes. Muniesa et al have made the important point that the qualification of particular objects is integral to making them calculable (2007). As Doganova et al stated; 'what comes to count as value can in the end only depend on what gets valued!' (2014: 2). This is an arena of both academic inquiry and professional activity, in which expertise and knowledge is claimed, produced and sold (and in this sense is a particular form of cost).

In terms of valuation within health care, economics (particularly applied health economics), has come to have a central role. This economisation has largely occurred through the conceiving and implementation of health care and drugs as economic goods (Muniesa et al 2007). Economic qualification however is only one of many forms of valuation that may potentially conflict. In asserting this multiple nature of value, Kaushik Sunder Rajan has used the term 'polyvalence of value' (2006). Rajan argued that we live in a time where we are forced to reconsider terms whose meaning was previously taken for granted, 'value' being one of them. These ideas were later developed in an article with Leonelli (2013):

The question of knowledge/value is not, and cannot be, simply one that asks what knowledge is or what value is. Indeed, we recognize the very polyvalence of these categories at the outset. For instance, value could refer simultaneously

to dimensions of the ethical and the normative, as it could to questions of market value (Rajan & Leonelli 2013: 465).

The terms 'value' and 'knowledge' can thus be conceived sociologically as both relational and an outcome of negotiation and social practice. Valuation is then subjective to the extent that it is tied to conditions of desirability and entanglements between people and things, and between people themselves (Helgesson & Muniesa 2013). There are no 'innate' values to objects or interventions that can be revealed through tests, rather value can be conceived of as a verb, and valuation as a contested process that takes place in particular contexts. This study attempts to understand the dynamics of the valuation of MBIs within broader institutional regimes.

Recurring questions within this literature thus remain how value can be assessed, and valuations accounted for. A crucial aspect of valuation however remains based on economisation, and cost as a central aspect of valuation is now critically explored in more detail.

- **3. Cost**

- **3.1 Dominant mechanisms**

Problems of resource allocation arise in many areas of health in terms of the opportunity costs involved in making funding decisions (Le Grand & Robinson 1992). Health economists have in the past used several methods of analysis; cost–benefit analysis (CBA) (measuring benefits and costs in monetary terms), cost-effectiveness analysis (CEA) (measuring outcomes in a form of fitting unit), cost-utility analysis (CUA) (measuring outcomes in some universal measure of health gain, e.g. the quality adjusted life year - QALY) and cost-consequence analysis (CCA) (comparing costs with a range of outcomes that are disaggregated) (Drummond 2005).

The concept of cost-effectiveness refers directly to health economics, and in many countries is a key consideration alongside evidence-based medicine (EBM) in gaining approval for new treatments and therapies (Will & Moreira 2010), and has been discussed by policy-makers as a priority within the NHS (Wonderling et al 2011). Determining the qualities and price of an exchanged good are central issues faced by the health service, as well as how evidence is used to make decisions over the 'value for money' of healthcare interventions and mechanisms of staff support, and how and

whether factors other than cost are taken into account in this process. As a unit of measurement QALYs usefully allow for comparisons among very different therapeutic alternatives (Sjögren & Helgesson 2007).

In assessing the cost-effectiveness and clinical value of healthcare interventions, economists have been accused of being 'dispassionate and unbiased' (these qualities not being negative in themselves), with potential implications of these attributes being a lack of incorporation of broader contextual factors *beyond* cost, such as patient experience (Culyer & Bombard 2012, italics mine). A broader 'societal' perspective has been recommended in which wider contextual factors - such as the national healthcare budget as well as the socio-economic background of patients, largely related to access to services - are incorporated on a formal basis into data analyses and decision making⁹¹ (Neumann 2009). As MBI community participant Teresa stated; *I should think some of the most deprived people who could get the most from this, have no access to it whatsoever*. GP Eleanor also argued that addressing the issue of access is key in gaining concurrent benefits in terms of savings:

Well it depends if you can show it is, I mean I think it probably is cost-effective (.) for the right patient, because some people could actually benefit and along down the line use fewer NHS resources, um, and certainly it seems like there's a lot of evidence to support it in anxiety and chronic pain and chronic fatigue (.) so I think it could be cost effective and you could make an argument for it but, it has to be um, (.) easy to access, I think those are the barriers.

A key question for healthcare policy is whether and how a societal perspective (which may or may not involve an increased focus on prevention) can be reconciled with government budgets and political priorities (Curtis 2012). Guidelines for clinical practice are one of the main tools by which clinicians, policy makers and patients hope to address the variability of health care provision.

○ 3.2 Guideline development

In the UK NICE is appointed to give guidance on the effectiveness and cost-effectiveness of health interventions (Kelly et al 2010) and to produce guidelines on specific conditions, that take into account cost-utility. In considering CUA there has been debate over NICE's 'threshold' figure of £20,000-£30,000 for the cost of an

⁹¹ Neumann has also argued that cost-effectiveness analysis (CEAs) should increase its transparency about the costing methodologies used, as well as the clarity in use of terminology (2009).

additional quality-adjusted life-year, above which a treatment will not be recommended for use in the NHS. Those who argue that the figure should be *more* have cited a willingness of the public to pay more (Culyer et al 2007; Towse 2009), with counter arguments citing a lack of evidence for this public willingness, and that higher prices for treatments are not always accompanied by health improvements (Refferty 2009). NICE of course does not set the NHS budget, nor has it been suggested that it would be right for it to have this role (Culyer et al 2007).

Moreira has highlighted gaps in understanding of the processes by which clinical guidance is constructed, what he termed 'repertoires of evaluation' (2005). An important contribution to valuation debates has also been van Loon et al's work on the construction of evidence-based guidelines (EBG) and clinical research (2014), focusing in particular on the role of doubt and uncertainty.

The rhetoric of EBG is that guidelines provide certainty for healthcare workers who are faced with patients with ambiguous complaints and treatment choices with unpredictable outcomes. That such strong rhetoric works is understandable, as healthcare workers are increasingly held accountable for their decisions... Yet, the idea that guidelines are free of uncertainty or the solution to clinical uncertainty is not realistic (van Loon et al 2014: 44).

Guideline development not only involves input (assessment of knowledge) but also the output (how users perceive the result). New articulations of knowledge can lead to specific forms of value, and new articulations of value can lead to specific conceptions of knowledge (Fairhurst & Huby 1998; Leonard & Sensiper 1998). As argued in Chapter 6, NICE guidelines are inadequate on their own in assessing value, and are only partial predictors of outcomes. Neither do they not cover the full cycle of care or are tailored to individual circumstances, and cannot be made without the experiential knowledge of healthcare practitioners and patients (van Loon et al 2014).

Expression of uncertainty can make guideline-devisers and researchers vulnerable in terms of funding for future RCTs (or phases within an RCT in the case of M4V as explored in Section 4.2), relationships with study participants, and standing within the highly competitive academic publishing community. Discussions of the evolving relationship between 'regimes of truth' and 'regimes of hope' have raised issues regarding the nature of expectations and the timing of future changes (Brown 2006). Van Loon et al (2014) asked how valuation work is then done to create a balance between acknowledging uncertainty and retaining credibility, and argued that the valuation practices that work better seem more capable of including forms of

uncertainty, and legitimately justify the choices made in the decision-making process. In terms of a definition of uncertainty, I followed Moreira definition as; 'the non-determinate or unsettled quality of a statement or knowledge claim' (2011: 1335). The reference to 'unsettled' here highlights the collective character of uncertainty, but also implies that work is needed to reveal uncertainties (or keep them hidden). 'Quality' in this definition underlines that knowledge valuation is not just the application of comparative techniques, but involves collective work (van Loon et al 2014: 46). Chapter 6 showed clinicians did not feel too vulnerable about expressing levels of uncertainty about the potential outcomes of M4V.

As the subject of both EBG and cost-based analysis, specific issues relating to MBIs are now placed in the context of the discussions above.

○ 3.3 Mindfulness-based intervention costs

Issues of cost-effectiveness were present in the data in terms of both the provision and take-up of MBIs, and included both whether the NHS had the willingness and capacity to provide courses and training to meet levels of need, and whether people would be willing and able to attend courses if provided. These questions were engaged with by a range of participants across the work packages, who were generally positive about the cost-effectiveness of this intervention.

In terms of the data reflecting previous cost-effectiveness analysis of MBIs in the literature, early proponents of this intervention positioning it as a cost-effective alternative to one-to-one therapies or pharmacological interventions (Teasdale et al 2000; Segal et al 2002). The logic of this argument came from MBIs being delivered in the UK and USA as predominantly group-based intervention to between 8 and 30 individuals. This was one of the key strategies of the champions identified in Chapter 6. When asked in the online survey how they would explain the popularity of MBIs, recurring themes were indeed the potential savings to be made through MBIs being a *group* rather than *individual*-based therapy, and that it fitted with self-help forms of treatment that could be practiced without external clinical or therapeutic input. MBI's were also stated to be cost-effective as a lasting skill that did not cost money to practice on a regular basis. In published evaluations Guarnieri (2010) has argued that cost savings through integrative approaches that incorporate MBIs can be achieved through lower utilisation of mental health professionals and GP contact, and the fact that MBIs are taught in groups, reducing provider time per-patient. Curtis (2012) drew

on Kuyken et al (2008) to provide the unit costs of a 12 week MBCT course in the UK. Table 3 below shows the breakdown of costs taken from Curtis (2012: 57).

Table 3: Breakdown of costs of single MBI

Costs and unit estimation	Unit cost 2011/2012	Notes
A. Wages/salary	£37,800 per year	Based on the mean basic salary for Agenda for Change Band 7 of the April-June 2012 NHS Staff Earnings estimates for qualified Allied Health Professionals.
B. Salary costs	£9,532 per year	Employers' national insurance is included plus 14 per cent of salary for employers' contribution to superannuation.
C. Qualifications		No information available
D. Overheads		Taken from NHS (England) Summarised Accounts.
Management,		Management and other non-care staff costs were 19.31 per cent of direct care salary costs and included administration and estates staff.
Administration and estates staff	£9,140 per year	
Non-staff	£19,865 per year	Non-staff costs were 41.97 per cent of direct care salary costs. Includes provider costs for office, travel/transport and telephone, education and training, supplies and services (clinical and general), and utilities such

		as water, gas and electricity.
E. Capital overheads	£2,682 per year	Based on the new-build requirements of NHS facilities, but adjusted to show shared use of both treatment and non-treatment space
Working Time	42.7 weeks per annum 37.5 hours per week	Unit costs are based on 1,602 hours per annum: 225 working days minus sickness absence and training/study days as reported for all NHS staff groups.
Face-to-face time	1:0.67	Based on data from the three MBCT therapists in this study
Length of sessions	2 hours: £49 per hour, £82 per direct contact hour, £165 per session, £14 per service user.	Two hour long therapy sessions

In this study the wages of the group facilitators were predictably the highest unit cost, a cost met by paying individuals in private courses. Van Ravesteijn et al (2013) also assessed MBCT as compared with treatment as usual (TAU) in treating patients with medically unexplained symptoms (MUS)⁹². In this study MBCT and TAU both acted to improve mental and physical health, but MBCT led to *earlier* improvement of mental functioning. At a willingness to pay of £57,933 per QALY, MBCT was estimated to be 57% likely to be cost-effective, which is not a particularly positive result on which to base future funding decisions, and is significantly above the threshold of what NICE currently uses (NICE 2013) (though because of a higher drop-out in the TAU condition the cost-effectiveness of MBCT may have been greater than shown in this study) (ibid). This study was also based on a very particular group and its relevance to a wider demographic be treated with caution.

⁹² Costs in this case were assessed by prospective cost diaries (van Ravesteijn et al 2013).

Psychologist Peter suggested that the broader view of health allowed through the QALYs needed to be taken by the Health and Wellbeing Boards (East Sussex Gov 2014). Peter used the '*Green Book*' used in government and in Whitehall as a guide on how cost-benefit-analysis should be done to illustrate his point, and suggested the use of a utility measure to change the policy-making process to be potentially quite radical⁹³. For mindfulness to be categorised as a form of complementary and alternative medicine (CAM) was also presented by Peter as not only undesirable and 'risky', but also as divergent from NICE guidance in terms of making a case for its cost-utility and in seeking NICE's approval. This argument relates to wider debates about the clinical governance (CG) of CAM in terms of safeguarding patients and assuring quality of service delivery⁹⁴ (Wilkinson & Gale 2015).

As set out in Chapter 3, cost made up a key part of the push for Talking Therapies as a particular model of healthcare provision, with the 2006 IAPT initiative based on the particular ideological premise of CBT-based interventions and self-help, not all of which may have been the preferred approach for patients (Walters 2008; Anderson & Brownlie 2011). SPFT manager Sue saw MBIs as '*one strand of how Talking Therapies could helpfully be offered*', implying her perception of them as both cost-effective (as Talking Therapies are required to align with EB requirements), and aligning with the political standpoint of that agenda which has included a focus on cost-saving and productivity, and the concurrent benefits of increased self-worth linked to employment. Health-economist John reflected this focus in the literature, and argued that people who were unemployed were more likely to suffer from pre-existing mental health problems, discussing the effects of being unemployed in terms of the impact on well-being and self-worth (Dolan et al 2008; Huppert & So 2011). Psychologist Peter also showed a cautious interest in MBIs as a '*reasonably cost-effective*' approach from a '*conventional economic point of view*' in assisting someone with a mental illness to get back to work, or to affect the behavior of young people in classrooms with the aim of achieving higher grades. Mindfulness teacher Rachel, however, discussed her frustration at the disparity between a developing evidence base for MBI use for the

93 In another argument regarding the potentially radical use of statistics, Doganova et al highlighted that a diverse range of actors have used the economic techniques that were imposed on them (2014). This may lead to further critiques of the need to quantify and monetise, or encourage a different form of critique, depicting numerical valuation as an instrument for critique (i.e. to make a persuasive case for continued or expanded funding for MBI provision) (ibid).

94 Given the high levels of public interest in CAM, it is perhaps surprising that NICE has not been asked to develop relevant guidance. Possible explanations for this were identified by Colquhoun (2007) in Chapter 3, as well as the potential consequences of the failure by NICE to include many forms of CAM.

treatment of recurrent depression, and funding available for the provision of courses for what in her view could be a cost-effective group treatment (she referred to Mindfulnet who support this cause) (Mindful Net 2014). Mindful Net is an independent mindfulness website that 'aims to provide everything you need to know about mindfulness in one place', and whose stated intention is to 'provide an accessible, secular resource for all in order to promote the benefits of mindfulness to a wider audience, and make it more accessible', and has an average 3500 hits per month (ibid). The SMC training in Sussex also embodied important aspects of the cost-effectiveness agenda, with recognition given to needing to justify its ongoing funding through emphasising the programme's ongoing benefit for patients, and the number of trainees who then went on to run their own groups (Marx et al 2013).

An important contribution to strategic work in this area has been a recent study raising ten methodological questions of which to be aware in future MBI economic evaluations, many of which are relevant to this study (Edwards et al 2014). The authors are based at the Bangor University Centre for Health Economics & Medicines Evaluation (CHEME), and in raising these questions they attempted to forge a consensus on how CBA or CEA could be done, and showed a community trying hard to show 'their' intervention as cost effective as well as clinically effective. They highlighted that the choice of economic analysis has implications for how the costs and effectiveness of an MBI are to be measured. These choices are also dependent on the amount and form of data available. Edwards also argued that an intervention cannot be cost-effective if it is not shown to be clinically effective first, and the research questions regarding the MBI, as well as the alternative intervention to compare it to, need to be clearly specified (ibid).

Costs are borne by course participants as well as organisations and individuals facilitating these courses. Responding to similar concerns, SPFT manager Kath discussed the expansion of the use of the term '*evidence*' to include wellbeing, clinical improvement, and the overriding importance of being able to justify the cost of MBIs in terms of the return on investment of resources and staff time:

Research outcomes, er, eval, getting the patient experience and feedback (.), evidence improvement, um, you know, through other, whether its a sort of clinical measure or a wellbeing measure that, you could, demonstrate to GPs, um, either its cheaper to deliver, you're getting better return on investment for greater clinical improvement and wellbeing, um, as an alternative to maybe, medication, more high cost treatments.

These discussions demonstrate difficulties in assessing costs even before carrying out

CEA or CUA, especially as it depends on the patient population. As well as symptom reduction, MBIs focus on the development of broader skills and levels of awareness, and the psychological models used in measurement inform both course targets as well as outcome evaluations. The SMC has made efforts over the past two years to establish collective evaluation methods for MBCT courses run in Sussex. A set of psychological criteria for mindfulness, well-being and resilience was developed along with an evaluation pack for SPFT-run staff and mental health service user groups⁹⁵. Clinical MBI training staff were very aware of this pack, but mindfulness teachers not affiliated with the Trust all used their own evaluation forms.

A therapeutic approach however should be seen automatically as cost-effective if delivered in large groups at a low cost per person, as effect that result from participation in these groups could be short-lived or small⁹⁶ (Drummond 2005). Study results need to account for attendance levels of course participants, as well as considering the outcomes used in evaluation, equity of access to courses and the surrounding context of cost, travel, and the emotional capabilities of participants⁹⁷ (see Chapter 5).

Psychologist Peter suggested that to make the cost-utility case for MBI provision required the '*crystallising of instincts around the broader impact of well-being and policy choices, moving it from a set of instincts into an empirical question*'. The strength of an evidence-base was also presented by Peter as the strongest tool to shift resources towards a particular intervention. The suggestion here was that MBIs remain seen at the policy level on an *instinctual* level, with a lack of empirical data to evaluate the therapy beyond the abstract feeling that MBIs are a 'positive' intervention, similar critiques of which have been made against CAM more broadly (Ernst 2000; Goldacre 2006). RCTs are commonly identified as a key means for this 'crystallising' to take place, and have become a medium of political engagement within biomedicine in this sense (Epstein 2008).

95 To compare across studies, Edwards et al argue for choosing commonly used questionnaires such as used in SMC's evaluation pack. This acts to support commissioners who are reviewing evidence to assess the benefit of seeing an improvement using a particular outcome measure (2014).

96 The issue of the longevity of mindfulness practice and its concurrent benefits (or lack of) will be returned to in Section 6).

97 Potential difficulties also arise in measuring the benefits of a MBI in terms of aiding in adjusting to and/or accepting difficult life circumstances and the relationship of these benefits to limited resources.

These issues are now set within a wider discussion of organisational logics, or 'regimes', and their embedding in social networks and day-to-day material practices.

- **4. Organisational logics**

- **4.1 Regimes of truth and hope**

This section addresses the questions; '*How are MBIs being engaged with and acquire currency*' & '*What are the implications for mental health policy and practice both within Sussex and nationally?*', by exploring a specific body of literature which explores approaches to valuation taken by organisations. Incorporating the agenda of valuation, Moreira & Palladino (2005) have argued that biomedicine in contemporary society is shaped by the two (seemingly incommensurable) logics of the 'regime of truth' and the 'regime of hope'. They argued that 'regimes of hope' can be seen in the way that evidence in the present day gives way to abstractions based on imagination, desires, and 'the yet not present' in the future. The paper responded to debates on the relationship between the present and future.

The regimes of hope and truth are argued to be embedded in 'usually far less visible social networks and material practices' (Moreira & Palladino 2005: 58). These networks and practices are considered in the context of SPFT in terms of aggregations of actors, and how these actors debate the purpose and value of MBIs.

Distinguishing between hope and truth in the 'political economy of hope' in US research and cancer treatment, Good argued that; 'enthusiasm for medicine's possibilities arises not necessarily from material products with therapeutic efficacy but through the production of ideas, with potential although not yet proven therapeutic efficacy' (2003: 3). MBIs *do* in fact have a proven therapeutic efficacy for the treatment of recurrent depression and chronic pain (with trials as a method for producing these findings), but there was also a distinguishable strategy of knowledge transfer through the SMC research output, teacher training programme and an annual series of Masterclasses. If hope can be evidenced through an emotional investment in the potential future of MBI research or provision, and truth is seen as evidence (returning the 'promise' of MBIs to their original claims), both are discussed in the data, with many individuals moving between these positions.

Individual's hopes in the future of MBIs were not framed in the ways discussed by

Moreira & Palladino (2005), but rather revolved as much around the utilisation of current evidence as it did through the production of ideas and an emphasis on compassion as a vehicle for these ideas. Regimes of hope in the case of Sussex have thus not become calculable objects of truth regimes, but are a rather more abstract collective engagement with MBIs (both within the trust and within wider popular discourse) as a creative intervention to be expanded within mental and physical health services.

In their paper Moreira & Palladino drew from the sociology of expectations literature (Borup et al 2006) to explore changes in the make-up and public consumption of science, and as a central aspect of both the regimes of hope and truth (2005). From the focus on emotions as a key theme throughout this study, the emotional aspects of expectations and hope in MBI's future are considered here in the context of Sussex.

○ **4.2 Expectations: hope against 'hype'**

Brown has argued that 'futures are contingent, they are imagined, fought for, resisted and embraced in the present, in order to gravitate an imagined future towards the real-time now' (2003: 36). This 'constructivist' approach to expectations differs from a more realist-based analysis, a position which assumes 'there is a calculable difference in the present between expectations and the real worth of something such that expectations can be adjusted 'rationally' according to fluctuations in value' (Brown 2006: 285). This study on the other hand supports Nowotny et al's (2003) argument for the inseparability of the two regimes and the inseparability of the present and the future (with the 'real' itself being a regime). The 'underlying fundamentals' of studies of rational economics can in *themselves* be seen as future-based abstractions that can alter the present. 'Value' therefore cannot be separated from expectation in either conceptual and empirical terms. I am in agreement with Brown however that there is still scope for such hopes to be analysed within regimes of truth without the use of binary divisions (2006). The true organisational logic at work can therefore be seen as a matter of co-construction.

Expectations are 'situated' and contextual in the sense that regimes of hope and truth can demonstrate a spread of expertise and knowledge in terms of which groups have the power and authority to judge future expectations. Levels of trust in that expertise also relates to the position of opinion leaders in Chapter 6.

The vision of the future of MBIs from participants of this study remained progressive through interlocking organisational practices; a simultaneous hope for the potential of this therapy, and an investment in the present day-to-day working of SPFT as a complex and dynamic organisation. Indeed, there may be more of a need for hope in the case of MBIs because of the lack of outside funding as with pharmaceutical research (DoH 2003; Goldacre 2006). Brown took up this area of enquiry, and drew on insights from the sociology of expectations in an attempt to explore changing connections and links between the tenses of the present and those of a promissory future (2006).

As discussions regarding opinion leaders highlighted in Chapter 6, the hope of these individuals was embodied through personal investment in mindfulness practice, whilst simultaneously existing within an environment of limited funding. Like Pickergill's study (2011), in some of the data a narrative of optimism (or regime of hope) was evident, but those in support of MBIs were tempered in their emotional investment and presentation of their hope, with expectations often being pragmatic through a mixture of truth and hope. People had not let go of their belief in MBIs, but what counted as this innovation may also have changed due to the therapy's expansion. Concerns around these changes were part of an ongoing conversation within the mindfulness community, including the risks of expectations being too high (Will 2010). This also relates to Brown and Michael's discussion of 'hope against hype' (2003).

According to the expectations literature people consciously seek to frame innovation quite early in the process as 'promising' and then manage their expectations accordingly (thus attempting to avoid the pitfalls of 'hype'). Observational data from attendance at the Centre for Mindfulness Research and Practice (CMRP) national Mindfulness Conference (2013) (Centre for Mindfulness Research and Practice 2015) as well as the Sussex Mindfulness Conference (2014) suggested that hope and expectations of MBIs could be said to be self-managed through opinion leaders' knowledge of the organisational restrictions within SPFT. The data reflected MBIs as managed in this way, both through the emphasis on evidence and the risks of dilution discussed in Chapter 6. Evidence for this could also be seen in SPFT advice for both patients and referrers which highlighted the need for other interventions alongside mindfulness. As discussed in relation to SPFT's framing of stress in the promotion of MBIs, these forms of imagining can use the (potentially indirect) tactic of making promises so vague that they are arguably not amenable to evidence and therefore

cannot be held accountable for it and this may be the case with the specifying of particular targets.

Reflecting the realism regarding risks of expansion, clinical Psychologist Trainee Philip argued that MBIs could become a 'go-to' referral option, to market to those for whom CBT did not work. Philip discussed the simplicity of mindfulness exercises as a strength in the context of an increase in expectations in the intervention:

I think people are very watchful about putting people into a box, and at the end of the day what you're doing is sitting down and noticing stuff, I mean it's it (.), there's no magic there, and I'm worried with the increasing expectations, the pay-off needs to be so much more, that mindfulness is walking into other stuff. It's just (.), I think the reductionism is almost taking away the simplicity of mindfulness (.). You're just sitting there and you're watching your thoughts or watching your (.), your breathing and so on (.), it's not rocket science. But I'm wondering whether the practice and the recognising the importance of doing that, is what makes a difference.

Reductionism in this case was not that referrals to MBIs were being made without due care, but that the importance of the therapy lay in the simplicity of the personal practice, rather than MBIs becoming a referral option for patients. In terms of debates within the mindfulness community, a point of caution has also been made by one of the key champions and mindfulness teacher in the UK, Ed Halliwell, that mindfulness is not a top-down approach that can be used to address any difficulty, and 'needs to be grown carefully' (2011: 47). This sense of caution very much fits with the predictions of the expectations literature (see Chapter 2).

Responses to uncertainty as Brown (2006) discussed can be used to explore how a lack of clinical significance in the M4V RCT may affect the future regime of truth of MBIs. Evidence of hope not being affected by the outcome of the M4V RCT can be seen in the 'Voices Clinics' still being pursued within Sussex, using mindfulness-based techniques as a treatment for distressing voices. The screenshot in Figure 22 below from the Issue 5 (23.4.15) of the SPFT Research Magazine (Sussex Partnership Research Magazine 2015) promoting M4V groups within the clinics presented as pilots.

Increasing access to therapies

M4V groups are currently available within the Voices Clinic which is being piloted at Brighton and Hove Assessment and Treatment Service.

Learn more about the lessons learned from the first year of the Voices Clinic in the next issue.

Figure 22: Issue 5 (23.4.15) of the SPFT Research Magazine (Sussex Partnership Research Magazine 2015)

Figure 23 below provides more information on the Voices Clinics to be offered within Sussex:

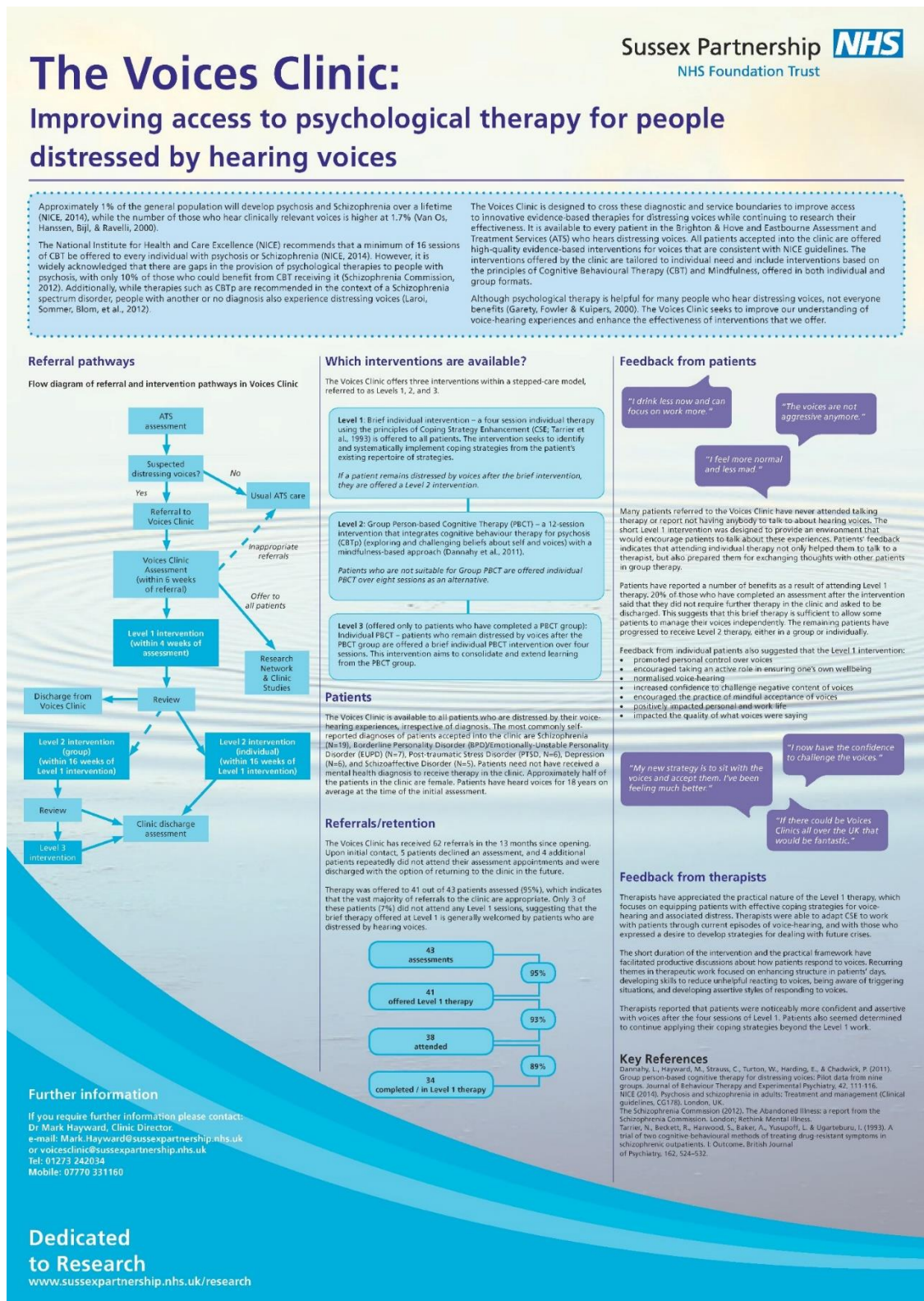


Figure 23: SPFT Voices Clinic Research Poster (SPFT library 2015)

If the regime of truth represents what was positively known, rather than what *could* be,

part of this regime was the particular value that MBIs represent in terms of what can be positively known about the experience of practicing this therapy in an embodied sense. The particularity of the values associated with and as a result of MBIs is now considered in more detail, first setting out how the holistic models explored in Chapter 3 have been articulated within the NHS.

- **5. Articulation of integrated models**

- **5.1 Beyond evidence-based medicine**

Evidence based medicine (EBM) has portrayed itself as a comprehensive model for decision making (Timmermans & Epstein 2010; Greenhalgh 2014), but has neglected the ways in which other forms of knowledge such as patient values and the ethics of care can be integrated meaningfully within research (Gupta 2011). In an example of efforts made towards this integration, a report for the Joseph Rowntree Foundation (JRF) explored mental health service users' views on common approaches to mental distress (Beresford et al 2010). At a time of growing interest in 'recovery' (Mackelprang & Salsgiver 1999), service users highlighted that the medical model still dominates understandings within mental health policy and practice in ways that are both damaging and unhelpful. Strong support was thus given for more social approaches in understanding and treating 'mental health issues', and countering the individualisation of mental health (Beresford et al 2010). These social approaches have much in common with the integrated models explored in earlier chapters.

Such concerns have been articulated within a movement calling itself 'values-based medicine' (VBM), which emerged from within psychiatry in the early part of the 21st Century, and sought to position itself to compliment EBM⁹⁸ (Hughes & Fulford 2005). This movement aimed to highlight the particular problem of psychiatric ethics and its connections with deeper philosophical issues such as the concept of selfhood and the

98 The practical application of VBM in contemporary mental health care remains limited (to the extent this application is discussed in the literature), though Brown & Brown have argued that the 2010 Patient Protection and Affordable Care Act (or 'Obamacare') in the US assures that some variant of VBM cost–utility analysis play a role through identifying high quality care, maximizing healthcare resources, and empowering patients and clinicians (2013) VBM was not referred to directly by my informants, though is nevertheless still of relevance as an analytic lens that asserts the empowerment of both patients and clinicians with which to explore the data.

influence of values on both practice and reasoning⁹⁹ (ibid; Baldwin 2005; McMillan & Gillett 2005; Brown & Brown 2013).

‘Values can be complex and conflicting, and it is here that the skills of values-based practice are needed if shared decision making is to happen within a shared framework of values. Just as a failure to access the appropriate generalizable scientific evidence can mean that flawed clinical decisions result, so (and perhaps more commonly) a failure to ascertain and work with the values affecting the individual consultation can also result in disaster’ (Peile 2013: 3).

By taking a ‘values based’ approach it is thus argued that ‘EBM’s connection to the humanitarian principles upon which it was founded will be strengthened’ (Kelly et al 2015: 69). Gupta has usefully highlighted however that in order for VBM to fulfill this role requires agreement with the positioning of ‘EBM as focusing on the facts of practice. Moreover, one must also concur that bioethics focuses on higher level principles or codes with relative lack of attention to the complex process of identifying and negotiating values in actual practice’ (2011b: 992).

Fundamentally there is a lack of agreement over values, pragmatic limitations on the time available for the application of this theory within stretched clinical contexts, a degree of assumption of the ‘facts’ that EBM represents, as well as agreement within EBM about potentially competing values. VBM thus needs to work within existing power structures as well as challenging them (Gupta 2011b). In the case of VBM its proponents suggest adding something *back* into the EBM model to ensure ‘good medicine’. Gupta is unsure they show how to achieve this. Within policy, the same concern with finding a human face for medicine has sometimes been visible in the growing emphasis on compassion in the NHS (Sussex Partnership Operational Plan (2015).

Any critical discussion of attempts to ‘value’ MBCT in Sussex, needs to account not only for these broader based discussions and cultural trends, but also local conditions that make it possible to go beyond cost and clinical effectiveness as the twin demands of EBM.

99 Discussions of selfhood are also highly relevant to psychological discussions on the nature of schizophrenia, as well as social questions based on the evidence of the impact of the social and emotional environment on an individual’s tendency to relapse (Hughes & Fulford 2005).

○ 5.2 Pluralistic values of Mindfulness-based interventions

The data showed that MBIs can be used in the consideration of different forms of value. The contribution of MBIs within biomedicine is notable both in terms of emphasizing holistic health and emotional wellbeing; often taking an explicit community or relational focus. MBIs are also of economic value as a monetizable part of both the health service and commercial sector.

Data highlighted the particular value of MBIs as compared to other dominant forms of treatment within biomedicine such as pharmaceuticals. In terms of the central differences between MBIs and pharmaceutical interventions, MBIs have been most commonly compared in the literature to anti-depressants as a treatment for recurrent depression. Some similarities include: both can be evaluated through RCTs; both are a form of treatment; both are a brand and a tradable good, incur a cost, and are a political issue. MBIs however are in an interesting position as a group of interventions subject to economic qualification that do not conform to the same critiques as pharmaceutical testing such as side effects, conflicts of interest and profit margins (Pollock 2011; Williams et al 2008). Indeed MBCT was stated by some participants of a recent RCT to allow more control and self-determination than anti-depressants. Individuals were better able to spot risks of relapse¹⁰⁰ (Kuyken et al 2015). MBCT can confer resilience and this sense of control as skills are learnt that address factors underlying relapse, with control being its own form of value (ibid). This is shown here through the experiences of Beth, a participant of M4V, when asked what she had gained from the course¹⁰¹:

100 This RCT involved a group of 424 adults from GP practices in SW England who consented to take either pills or to take part in an MBCT course. Those participants who were assigned to MBCT had eight group sessions of more than two hours in addition to daily homework, and were offered four follow-up sessions over the following 12 months. The patients gradually came off their medication, and those in the pharma group stayed on their medication for two years. Results showed similar relapse rates between the two groups (44% in the mindfulness group and 47% for those on the pills). There were five adverse events in each group, including two deaths (Kuyken et al 2015).

101 Through this gaining of a sense of control also came a celebration of their own difference through interpersonal relationships and understanding the relationship between self and other. Participants made an association of their own voice finding with feeling in control in situations of social interaction, between feelings of alienation and openness to difference, and a negotiation of difference between and self and other. This becomes an affirmation and confidence about difference (psychotic experiences being hard to hold).

Oh yeah (.) that you can be in control, they don't have to rule you (.) the voices, because you are in control (.) you can be, you know, and it's true (.), when I'm thinking about it and the voices are there I think 'no I'm not listening', I think 'go away I'm not listening'...

/

And the, the course helped me understand that, you know, I didn't have to let them, you know, tell me what to do or, be in charge of me. It helped me understand it better, the course, because I didn't understand very much you know, what to do with the voices. But, they taught me that I can be in control, and that I can be a lot better than what they say I am.

MBIs can thus exemplify social model of recovery, through empowerment, choice, control, and personal fulfilment potentially enabled through personal practice (Drake et al 2014; Perkins 2001). As Deegan has powerfully argued, 'the role of recovery is not to become normal, but to embrace the human vocation of becoming more deeply, more fully human' (1996: 92), a role not dissimilar to that of mindfulness. This therapy could therefore be seen as a positive form of self-management (Greenhalgh 2009).

In terms of the relationship between MBIs and EBM, data from this study also supported Fulford's argument that values can operate in parallel with EBM (2005). Community course participant Mark suggested that the value of MBIs can be maintained *within* an evidence-based structure. He used the example of the raisin exercise used as a standard part of the 8-week MBCT and MBSR course, in which participants are given a single raisin and are encouraged to observe, feel, smell (and even listen to) it before tasting it, with the aim of noticing the physical sensations and the psychological reactions to wanting to eat it immediately:

I: Yeah, it's an interesting point whether, you know, does it matter whether the maybe 'spiritual aspect' is being diluted if it's just becoming this kind of CBT format (.) =

P: = but the spiritual aspect already exists within a structured teaching method, so it's already there anyway, um, in fact, you know, it's, it's, you can tell by the repetitiveness that everybody does, you mentioned the raisin, well, everybody does the raisin exercise, well that means it's basically a kind of syllabus training exercise. It's, it's um, so it already exists within quite a formal structure (.), so, I don't see how that would necessarily undermine it, if it was, I just don't see how that's necessarily a problem, I mean, er, all of these er, practices have a structured framework in which they're, allowed to be taught and learn, and evolve, and be effective, so (.), er, even, even sort of one-to-one counselling which feels like it's not very formal 'cause they're just saying 'well how do you feel?', I mean even that, they're trying to get to a point where they've got you thinking in a different way, it's all structured isn't it, there's no non-structure to any of it, it seems to me.

In this quote, an emphasis on spirituality is not seen as contradictory with EBM, rather the formal framework or structure can encompass that 'aspect'.

Fears over the loss of the 'essence' of MBIs through increased and unmonitored roll-out were recurrent themes in the data. MBIs had much to gain from endorsement and alignment with EBM (Wiese et al 2010), and those facilitating this therapy were thus required to adhere to the evidence-based 8 week course content and structure (Scambler 2000; Saks 2003). This structure, brought over from the US MBSR course and re-established in an MBCT format in the UK, was the basis of the RCT's behind NICE's endorsement. Potentially adding to this complexity, there have been recent RCTs now using a 5-week course structure (Mitchell & Heads 2015) and anecdotal evidence from a member of the SMC during ethnographic field meetings that this might be a direction taken in the future. Clinicians running RCTs of MBI courses may have dual (and potentially conflicting) priorities of long-term patient well-being and the cost of running courses within a trial.

MBCT may not have been recommended by NICE without adhering to the structure previously part of the IAPT 'talking cures' agenda, as Clinical Psychologist Matthew stated:

I think there is a popularity to it, but its kind of become (.) um, (.) tagged with this whole IAPT kind of way of working and, um, i-, you know, the kind of economic agenda behind therapeutic approaches (.), which again probably would, wouldn't kind of tie in to the kind of roots of mindfulness practice necessarily.

It is difficult to specify in detail how adhering to the pre-set 8-week format affected the value of MBI implementation, with the manifestations of value not always being immediate or obvious. Despite difficulties surrounding branding and quality control (also identified in Chapter 6), mindfulness supporters in Sussex *did* want to find ways to articulate other values than clinical and cost-effectiveness, and the 'spiritual' aspects of the course could be said to articulate alternative values to EBM. The position of MBIs within the broadly secular context of the UK is now explored.

▪ 5.2.1 Cultural critique in secular context

In a free-text section of the online survey when clinicians were asked what they attributed the popularity of MBIs to, the following responses demonstrated the role they saw this therapy played as a counter to the dominant culture in the UK:

- *Addresses a cultural malaise around manic busyness.*
- *Provides a refreshing change to our culture of fast-paced and task-focused activity.*
- *Counter to Western focus on striving, achievement, judgement, provides an alternative.*
- *A movement in popular culture to become more aware of the body and its role in our wellbeing.*

Following evidence showing the benefits for mental health and emotional wellbeing of a supportive community presented in Chapter 5, Clinical psychologist Brandon raised the question of what a support structure paralleling that provided through the Buddhist tradition would look like in a secular context:

P: I think the interesting challenge, or one of the interesting challenges is, what (.), I guess, in the spiritual tradition, in Buddhism, there's a whole, (.) it's been sort of thought as what's useful to support practice are communit-, I guess Sangha, in terms of community, um, Dharma, in terms of the knowledge base (.), um, and, and teacher. And so there's a whole sense of community, structure, ethics (.), you know there's a whole wider framework designed to support people in practice (.) or partly in relation to practice.

I: Yeah.

P: And I guess a question that comes up for me is 'what might that look like in a more secular context?' (.), so, there's a sense of, I guess Buddhism, that you know, from perhaps those most experienced with these sorts of practices, that these are the things that are helpful (.) the community and the teaching and the wider framework. Um, and that almost as a necessary, and even with those things I guess that, as people, we find it challenging, or many people find it challenging to practice and embody those ideas. So, how can we (.), what might that look like? And how can we have some of that support in a more secular way, for people who don't want to access um, you know, in a Buddhist tradition (.).

Brandon implied that it was more difficult to practice and embody a sense of community in a secular context, and that the support of a regular MBI group and follow-up sessions (provided either through privately run courses through SPFT or by teachers in the community) could be a step towards a 'Sangha' (a Buddhist monastic order) in a different form. Mindfulness teacher Izzie highlighted the support available, that *'even in a non-Buddhist culture like this (.), you know there's retreat centres, there's teachers, there's loads of books, there's groups, there's lots of things to keep you on the straight and narrow, you know, keep you practicing and it's hard to just carry on practicing just by yourself. That is hard.'* Izzie felt that despite the difficulties that more follow-up provision was crucial for the benefits of MBIs to continue.

Conversely for a practice largely based on Buddhism, the perceived increasing secularity of the UK was also presented as an advantage in the wider application of mindfulness for stress and wellbeing as well as for specific health conditions by mental health nurse Steve:

Um (.), er (.). but then I think in terms of the clinical applications, I think it would be um, very applicable for, for mental health conditions, and neurological conditions (.), because a lot of mindfulness research relates to the brain, and the nervous system, so that's, that's something that you can zero in on and, and sort of have some evidence for, but then also what's interesting is the wider applications um, for anyone in um, in terms of stress and er, just general wellbeing. Um, but then it's fitting it into the world-view, and er (.), I don't know (.), religion, and how it (.), how it can sort of, dovetail with people's beliefs or their- (.), but then I mean, the UK's becoming increasingly more secular now, so, that may be to mindfulness's advantage (.).

As well as mindfulness being seen as a societally acceptable form of secular spiritual practice, the advantage discussed by Steve may also be a result of the receptivity of UK society to a treatment based on evidence for the benefits of MBIs on the nervous system, with increasingly quantifiable outcomes.

We saw in Chapter 6 that contact with a particular set of values can form a base of receptivity to MBIs, and that this is demonstrated to some extent through SPFT's recognition of staff wellbeing and use of 'Compassion Circles' training¹⁰² (Sussex Partnership Staff Wellbeing 2015). The broader focus on the role of compassion in stress reduction was reflected in the data by some SPFT employees such as clinical psychologist trainee Philip, who saw MBIs as a 'compassionate template' for a way to step back from stress and striving:

I think mindfulness is quite nice, because it's, for me I found it quite useful, because it's from a different culture (.), and you know the sort of, if we're thinking about the society that we are in Western culture that's driving to succeed, to succeed in a very competitive society, and the emphasis on possessions as well. And maybe the reduction in the importance of relationships and family and lifespan, er towards to ideals erm of, being beautiful and rich and all those kinds of things. And I'm wondering whether more kind of Eastern philosophies like Confucianism and Taoism and all that kind of-, well, maybe offer a more collectivist, philosophy there, where really it provides a more compassionate template of how to, you know, of what reality

¹⁰² Like mindfulness training, Compassion Circles aim to build up compassion for the self and other, and personal and organisational resilience and well-being as a counter to the mental and physical effects of stress (Sussex Partnership Staff Wellbeing 2015).

you want to see your life through. So for me I suppose who's a bit fed up with the amount of striving that people have to do in order to work, and that didn't really seem to me to fit it didn't, it seemed a bit false. So I guess I found it quite refreshing, and so because of that, I suppose I find it quite grounding (.) really, and just thinking 'ok well what's actually happening' (.), and I think it sort of de-prioritises things that maybe I'd thought of as being quite important, and, you know, emphasises what people sometimes forget.

Parallels can also be drawn from Philip's thoughts on the collectivist philosophy behind mindfulness, and connections between the mind, body, emotions and society emphasised in previous chapters (Cummings et al 2007; De Leersnyder et al 2014; Burkitt 2014). Malloch et al argued that most healthcare leaders and caregivers intuitively appreciate the significance of effective relationships and their connection with positive patient outcomes (as well as financial security) (2000). There has been a lack of empirical data and support for these relationships in the past, leading to a lack of resources and valuing of these relationships. Qualitative research such as this study has a role to play in helping to imagine the value of MBIs in terms of the potential part this therapy can play in the humanisation of healthcare¹⁰³ (Todres et al 2009).

This chapter now considers how MBIs can articulate alternative values through the particular approach taken by SPFT to the incorporation of patient values. The M4V trial and the mechanisms behind this RCT, one of the most recent applications of MBCT for diverse populations within Sussex, are used to illustrate some key issues which arose in the data.

▪ 5.2.2 Value of '*Mindfulness for Voices*' trial

SPFT self identifies as a space which listens to people and takes an explicit focus on staff wellbeing and service user involvement in research and service design and implementation (Sussex Partnership Lived Experience Advisory Panel 2014). As set out in Chapter 3, RCTs generate a particular form of 'evidence', one which contributes a central part of SPFT's research strategy. The '*Mindfulness for Voices*' (M4V) trial followed this strategy, as well as representing the concurrent efforts of the Trust in terms of user-based outcomes, the role of qualitative research, and efforts to be at the forefront of developing creative interventions for the treatment of complex conditions.

¹⁰³ 'Humanisation' is used to describe health care influenced by core dimensions of being human (Borbasi et al 2013). Todres et al have argued for a two way relationship in which a humanizing framework of values for healthcare is a focus for qualitative research, and where the qualitative research also supports the humanising of healthcare (2009).

Whilst no significance was found on the primary outcome (psychological distress) relative to control, significant differences were found on voice-related distress, voice-related control, depression and recovery (CHOICE), and the findings for depression was maintained at six-month follow-up.

The aims of most Hearing Voices Group (HVG) models are to provide a sense of being normal, help participants to understand their voices, and enhancing feelings of control over their own lives. These aims are however rarely explicitly tested in studies¹⁰⁴ (Ruddle et al 2011). Despite evidence for the relationship between social activities and clinical change in psychosis, there has been a lack of effective measures of time use, with check-box measures also an imperfect format (Jolley et al 2006). A Time Budget measure - which asks participants how they spend their time during a set period - was thus designed to assess activity levels for this patient group as a more effective measure. This measure should be completed as a structured interview with respondents, and was designed to be individualised and sensitive to change¹⁰⁵ (ibid). CHoice of Outcome In Cbt for psychosEs (CHOICE) was the measure used in M4V meant to capture patient-reported outcomes for recovery (Greenwood et al 2009). This measure can be said to embody the values of Service users in terms of the outcomes being generated by the users themselves. The CHOICE measure included statements such as those below, with the same 2 questions answered about each statement.

- *The ability to approach problems in a variety of ways*
- *Self confidence*
- *Positive ways of relating to people*
- *The effect of unpleasant experiences (e.g. beliefs, thoughts, voices, feelings) on my life*
- *Feeling overwhelmed by negative feelings (e.g. fear, depression, anger)*

Participants were asked to cross on the line to show how they had felt about the statement over the previous week¹⁰⁶. For each statement the questions were set out in

104 The fact that participants on HVG studies are heterogeneous might also hide the efficacy of these groups, as trials measure group changes so may not capture changes in the omnipotence of, or distress caused by the voices for each individual taking part in the course.

105 There have also been moves to use the Time Budget approach within the SUPEREDEN (Social Recovery oriented therapy for early psychosis) study, which is aiming to investigate how young people with psychosis can be helped to take part in more activities to improve social recovery and to reduce symptoms of hopelessness and anxiety.

106 In terms of the process of creating these measures, service users who had been in the CBTp group took part in focus groups to discuss their desired outcomes. A qualitative thematic analysis was then used to identify themes specific to the trial before it began in 2013. The

Figure 24 below;

(a) How would you rate yourself for this?	0 1 2 3 4 5 6 7 8 9 10 worst best
(b) How satisfied are you with this?	0 1 2 3 4 5 6 7 8 9 10 not at all satisfied very satisfied

Figure 24: Format of CHOICE measure questions for patient-reported outcomes for recovery (Greenwood et al 2009)

Data from M4V supported previous anecdotal evidence that both therapists and service users (SUs) benefited from the mindfulness groups, and SUs often commented on it being the first time they had felt able to discuss their voices. The choice of outcomes investigated within RCTs have ethical implications for what constitutes health and how to achieve it, as clinical researchers can value outcomes differently from service users¹⁰⁷. We saw in Section 4.1 that the concept of recovery has become increasingly important in mental health service provision (Bellack 2006), yet SU concepts of recovery and priorities for intervention may differ from those of clinicians¹⁰⁸.

As stated in Chapter 4, Ruth Chandler (the lead for SU experience for SPFT) and I carried out a qualitative study alongside the main M4V RCT in order to explore different concerns to the clinical team running the trial. The Lived Experience Advisory Panel (LEAP) for M4V were initially consulted over an interview schedule for the qualitative research, and this group then created an initial topic guide which was circulated to the M4V research team. The team added their non-clinical curiosities to the schedule. The LEAP chair and myself then narrowed the list down to 10 questions including both sets of interests.

The qualitative study we carried out alongside the RCT did not use any existing

resulting questionnaire from agreed items based on these themes was piloted with service users who had not received the CBTp intervention in order to check that it was user friendly (Greenwood et al 2009).

107 Outcome measures for CBTp have drawn from pharmacological studies, and focused on changes in symptoms rather than outcomes like fulfilment or distress (Greenwood et al 2009). The CHOICE measure aimed to reflect the desired outcomes of CBTp as well as service user priorities.

108 Service users have stated that symptoms can be *less* debilitating than for emotional difficulties, stigma or social exclusion (May 2000, *italics mine*). The reduction of symptoms has also not necessarily been enough to bring about an increase in quality of life, with corresponding concerns such as for example control, choice, and a sense of empowerment (Perkins 2001).

measures but asked what recovery meant to each participant and whether participation in M4V had helped in this recovery. Overlapping themes were evident between the user-defined concerns that made up CHOICE, and the contents of the topic guide devised by LEAP as part of our qualitative research. These overlaps concerned a sense of selfhood, choice, control, and an understanding of the participants' mental health and their past. The qualitative data could be used to support the unanticipated therapeutic benefits of being in a group, and could be used to argue, tentatively and given the small sample size, that clinical interventions could improve recovery outcomes. The role of the LEAP also evidenced the role of SUs in the articulation of alternative values to the concerns of the clinical team running the trial, a possible example of PPI successfully in action.

Relating back to the argument of Moreira and Palladino (2005) in Section 4.1, while the M4V trial was ongoing, clinician respondents to this study (as well as many other stakeholders) identified they were able to feel they had reconciled the regimes of hope and truth rather than moving between them, or seeing them as located in different groups (with hope located with patients waiting for an effective treatment for distressing voices to come in the future, and truth located with the clinical team running the trial). In the context of the messiness of psychological therapy trials, and ongoing debate in the field about the outcomes which should be measured, the trial team felt that there was strong enough evidence to offer mindfulness groups for patients experiencing distressing voices in routine clinical practice within Sussex. This outcome seemed to fit with the idea that the way the results of the trial revived tensions between truth and hope amongst the clinical team, referring clinicians, and the trial participants¹⁰⁹. How this roll out will affect the existing reticence of clinicians about referring patients to MBIs once M4V is formally published currently remains a matter of conjecture¹¹⁰.

The future provision of services for this group of service users also remains dependent

109 I did not have data on participant reactions to the M4V trial results, which may make an interesting follow-up study investigating the influence of published results of M4V on the experiential memory of the trial participants. Recommendations have been made that participants of research be shown the results of studies without any corresponding research to show how this should be managed. Literature exploring these issues has advised caution in routinely providing trial-results to participants, or simple claims of this provision being a form of paternalism (Dixon-Woods et al 2006).

110 With this group of participants clinician self-experimentation and the role of experiential knowledge discussed in the previous chapter are not as relevant because of psychosis being the specific condition being referred for: i.e. there are not many referring clinicians with psychosis.

on multiple factors beyond trial outcomes. Porter has argued that the value of healthcare for patients often manifests in longer-term outcomes like sustainable recovery or the need for ongoing interventions and behavioural patterns (2010). Individual patient costs and health outcomes therefore need measuring longitudinally (ibid). Several health economists have added their voice to the argument that it is both cheaper and easier to prevent the onset of disease than to treat one once one has developed (Edenfield & Saeed 2012). The focus on prevention rather than fire-fighting existing mental health conditions requires the (pre-emptive) expression of a particular set of values beyond short-term outcomes.

Embodied emotional experiences were shown in the data to have their own power as a particular form of ‘evidence’ for many individuals who practiced mindfulness regularly. These findings suggest the need for a dual strategy of clinical evidence reinforced by embodied emotional experience for influencing what happens in practice (Piele 2013). The previous chapter showed the clear power of people’s experience that MBCT was helpful for them – which helped create ‘champions’ and strong narratives about the value of the therapy. In this chapter it should be noted that in the case of the M4V trial such experiences were made formally visible as additional outcomes measures.

- **6. Sustaining value**
 - **6.1 Prevention as partial imagining**

Beyond this specific patient group, and similar initiatives to tie the value of the therapy down for individual conditions as essential for NICE and a biomedical approach, other initiatives in healthcare can be narrated in more open terms around prevention and children and young people, and even (as discussed in section 6.2.1) staff.

Rather than prevention as a form of value itself, value can be conceived as the *use* of MBIs in treating a state of ‘dis-ease’ before it reaches the need for a ‘cure’ and an individual becomes a patient. Prevention has been one of the four key areas of focus for the ‘*What Works*’ initiative (see the government publications; ‘*No Health Without Mental Health*’ (2011) and ‘*Mental health promotion and mental illness prevention: the economic case*’¹¹¹ (Knapp et al ed. 2011) (Rycroft-Malone et al 2014).

¹¹¹ One of the six outcomes in the Welsh Strategy ‘Together for Mental Health’ is: ‘Access to, and the quality of preventative measures, early intervention and treatment services are improved and more people recover as a result’ (Rycroft-Malone et al 2014: 3).

Despite the discourses of these initiatives, psychologist Peter highlighted that out of the 10% of Gross Domestic Product (GDP) spent on health, 4% of this figure (and less than .5% of the total health research budget¹¹²) is actually spent on prevention (Knapp et al ed. 2011). Out of that 10%, an estimated £2.7 billion is spent on treating excessive alcohol consumption, but only £8.7 million on promoting healthy levels of drinking (this seen in a context of the £800 million that is spent annually on promotion by the alcohol industry) (ibid). Another psychologist Daniel expressed relief at the increased visibility of mental health issues in mainstream political discourse, whilst acknowledging that he was unaware if this visibility would be supported by dedicated funding streams.

MBIs aim to engage the whole person and the range of mental, emotional, physical, social, spiritual and environmental factors behind the health of the mind and body (Guarneri 2010), and are being offered to healthy populations on an increasing basis as well-being and resilience-building strategies (Edwards et al 2014). MBIs were partially imagined as a preventative strategy in the data. Mindfulness Teacher Izzie viewed her role within the private sector as forming a preventative safety net for those who cannot access NHS services:

I: So do you have any other comments?

P: So but, catching people before they're so stressed they're signed off work for weeks or months, before they're depressed and have to, you know, really suffer, I think it would be good to have this kind of thing as preventative (.), so GPs can prescribe and say 'go away and eat your five a day and, and get a pedometer and walk 10,000 steps' and all the sorts of things we're, we're told. Um, the sort of health advice you get (.) I think it would be great to sort of have it as something else that GPs surgeries could offer = So that, that's my only thing really, that I would like to see it used as a preventative thing, and that's how I see my role in the private sector really because I can teach people who wouldn't get it on the NHS because they're not bad enough yet, I mean why should they wait five years till they're bad enough?

A similar sentiment was expressed by MBI course participant Daniel:

I think that mindfulness is an opportunity to try and get in there before, you know, before things get out of hand. (.) I mean, it's not going to stop everybody, and in the most extreme forms of depression and anxiety and other forms of mental illness that may have a sort of, biological element to them, it's not going to solve all those perhaps, but it might mean that more people go through life, um, with some mechanisms to help them.

¹¹² And as Peter went on to comment, most of that .5% is spent on compliance, rather than on research into other interventions such as MBIs.

As part of this strategy, Clinical psychologist Brandon picked up on the preventative focus of the early transmission and teaching of mindfulness skills in school environments, with potentially great significance on long-term well-being as well as educational achievement (Mindfulness in Schools 2015):

Yeah no I do feel optimistic about it, because I think people are seeing benefit's from it (.) um, so, i-, it wouldn't surprise me if it does spread. Um, I think mindfulness in schools actually, is some ways is (.), in some ways is the most exciting area. I think, it moves it away from, not that it shouldn't be in-house, and shouldn't be for staff and all this sort of thing. But there's more of a sense of 'this could be another skill for living' (.) as opposed to an intervention for a health problem.

Another key manifestation of the preventative approach is adapted MBCT courses for children and adolescents within SPFT. The screenshot below in Figure 25 details the courses running since 2010 as part of Child and Adult Mental Health Services (CAMHS) (Sussex Partnership Child and Adult Mental Health Services 2015).

Mindfulness in child and adolescent services

Since 2010, CAMHS practitioners within Sussex Partnership Foundation Trust and Brighton & Hove Council have been working in partnership to develop, deliver and evaluate a seven-week MBCT-adapted course for young people (14-18 years) coping with stress, anxiety and depression.

With research and supervision support from the Sussex Mindfulness Centre, and the help and feedback from young people and parents, the course continues to be revised and developed to meet the needs of young people locally.

Young People from Brighton and Hove CAMHS are currently working with Surrey University to develop a Mindfulness App for young people.

Our lead for mindfulness in child and adolescent services, Dr Brenda Davis, is speaking at this national conference (click the link to open the flyer for further information): [cbt_symposium_flyer.pdf](#)[cibt_symposium_flyer.pdf](#)

For more information about Mindfulness in CAMHS please contact Dr Lana Jackson (Brighton & Hove Community CAMHS) lane.jackson@brighton-hove.gcsx.gov.uk and Brenda Davis (Brighton & Hove Specialist CAMHS) brenda.davis@sussexpartnership.nhs.uk

Feedback from Young People

"I'm a lot better about going to school and when I'm at school I don't get so nervous. I don't think about what other people are thinking about as much. It helps me to concentrate more on what I'm doing" (female 17yrs).

"I catch myself earlier in panic stages, and can calm down better" (female, 15 years).

"I know how to take a breather which I can use throughout life" (Male, 16yrs).

Figure 25: SPFT website information on MBIs for Child and Adult Mental Health Service (Sussex Partnership Child and Adult Mental Health Services 2015).

If a focus on MBIs as a form of prevention can be seen as a partial imagining of an integrated health model in a temporal sense, this section now highlights three key themes from the data regarding potential mechanisms for sustaining the value of this intervention.

- **6.2 Specific mechanisms**

- **6.2.1 SPFT and staff values**

The first mechanism for maintaining the value of MBIs was by SPFT fulfilling its stated values, and this intervention being made a staff issue. In 2009 the Department of Health *'The Boorman Report'* explored links between the health and wellbeing of NHS staff, and effective and efficient care (Boorman 2009). Boorman concluded his review by stating *'Protecting and improving staff health is not a fluffy, cuddly thing to do, but rather a key enabler to support improvements in high quality care, patient satisfaction and improved efficiency'*¹¹³ (see Section 6.2.2 below on perceptions of MBIs as 'fluffy').

In being promoted as a mechanism for staff and patient wellbeing, SPFT specialty doctor Becca stated that *'it [mindfulness] has to be evidenced-based, there's no way around it, to be integrated. But er, I think if the evidence gets stronger and stronger, it should be incorporated into the clinical practice'*, moving beyond staff wellbeing into clinical ambition. GP Eleanor also argued that the more that MBIs are strategically embedded within teams the more value may be maintained through mainstreaming and rise in awareness:

Um I think er, um, so, different ways, so if (.) it doesn't get kind of embedded as a, you know, with a strong evidence base and infrastructure available to deliver it, then it will, it won't persist I don't think (.), but I think if patients are finding it beneficial, and (.) you know enough, if you find a cohort of people and are looking at the outcomes over time, um, to see whether it's cost effective, you know, whether it does have meaningful outcomes for patients. But I think people are really looking for things like this because it is essentially pretty inexpensive, it's pretty um, safe, and it could over the long-term really alter the course of a patients kind of, experience, um, so I guess I'm cautiously optimistic ((slight laughter)).

Classic management of expectations language was expressed in the phrase 'cautious

¹¹³ A recent review by the Institute of Employment Studies (IES) also made recommendations for improving the health and wellbeing of employees, with a focus on the role of line managers as well as organisational culture and context (2014).

optimism' (a strategy discussed in relation to later life by Shrira et al 2011). NHS manager Kath also highlighted cultural challenges to be overcome in terms of whether or not people see a specialist Mental Health Trust's core business as delivering mindfulness. She also appeared to suggest that these were being overcome in stating 'the results speak for themselves'. The regime of truth here was established by empiricism overriding cultural skepticism. GP Eleanor also expressed 'cautious optimism' dependent on this innovation being embedded with a strong evidence base and infrastructure available to deliver it:

I think if patients are finding it beneficial, and (.) you know enough, if you find a cohort of people and are looking at the outcomes over time, um, to see whether its cost effective, you know, whether it does have meaningful outcomes for patients. But I think people are really looking for things like this because it is essentially pretty inexpensive, its pretty um, safe, and it could over the long-term really alter the course of a patients kind of, experience, um, so I guess I'm cautiously optimistic ((slight laughter)).

The intention to implement these policies in practice in Sussex is evident in the 'Better by' statements touched on in Chapter 6 which state the SPFT's underlying commitments (Sussex Partnership Patient Experience 2015). Along with the Compassion Circle training, MBIs have contributed to meet the stated values of SPFT through the drop-ins, staff training programme, and ongoing CPD focusing patient and staff well-being¹¹⁴. Mindfulness teacher Janet discussed this sense of community through her experience of running staff drop-ins:

I mean people, you know, I'm 63 now and you know, people've come along to my groups in their 60s and 70s, because we don't have an age limit (.), who've, you know, who've never meditated before. And have really found it helpful, and have come along to the all-days, I'm thinking of one person in particular, who then started to come along, not to become a Buddhist, but went along to the Triatna mindfulness drop-ins there and, um, it just brings this sense of community as well.

In terms of the professionalisation of MBIs and the availability of CPD, Figure 26 below shows the booking form for the Master classes available through the SMC in 2014, with the available classes reflecting the range of areas relevant to clinical practice, including chronic pain, young people, and a consideration of the Buddhist background to

114 The 'Implementation NICE guidance for workplace wellbeing' report from the Royal College of Physicians concluded that; 'the workforce is the NHS's most crucial and costly asset. Making staff health and engagement a central trust value will increase productivity, avoid financial waste and contribute to better patient care' (2014: 7).

mindfulness¹¹⁵. These classes have continued into 2015 and beyond.

115 That two of the classes in the program were dedicated to this topic is potentially a reflection of the concerns that an 'essence' might be lost without this focus.

Sussex Mindfulness Centre
Master class Application form

To be completed by applicant				
Personal Details:				
Name:				
Email address:				
Correspondence address:				
Contact Number:				
Where did you first learn of this course?				
Do you currently work for Sussex Partnership Trust?	Yes		No	
Please indicate which master classes you wish to attend – The Mindfulness Conference				
2014 Events				
* Part 1 of Buddhist Background to Mindfulness: in MBCT/MBSR <i>Taravajra and Karunavira</i>	RESCHEDULED TO 24TH JANUARY 2015			
* Sussex Mindfulness Centre Conference <i>Keynotes: Willem Kuyten and Chris Cullen</i>	19 September 2014			
* Part 1 of Mindfulness and Chronic Pain: Softening Around the Hard Edge of Pain – Mindfulness-based Approaches in a Pain Clinic <i>Catherine Cameron</i>	3 October 2014			
+ Group Process and Leader in MBCT/MBSR <i>Taravajra and Karunavira</i>	18 October 2014			
* Part 2 of Buddhist Background to Mindfulness: Digging Deeper to Understand the Buddhist Context of Mindfulness <i>Bhante Bodhidharma</i>	27 October 2014			
* Part 2 of Mindfulness and Chronic Pain: Mindfulness for Health – the Breathworks Approach to Mindfulness-Based Pain Management <i>Vidyamala Burch</i>	4 November 2014			
** Mindfulness for Young People in Clinical Settings <i>Brenda Davis, Lana Jackson and Karunavira</i>	7 November 2014			
<p>Master classes cost £75 per person – except the Sussex Mindfulness Conference, which is free. The Mindfulness for Young People in Clinical Settings class will cost £30 and must be paid by cheque.</p> <p>* Open to the public and to people not involved in Mindfulness teaching.</p> <p>+ These workshop days utilise and develop participants' current teaching experience. Therefore, these days are for mindfulness teachers who have completed MBCT/MBSR/Breathworks teacher training or have experience in teaching mindfulness-based approaches.</p> <p>** This class is open to CAMHS or other clinicians working with young people who are interested in developing their Mindfulness skills with a possible view to pursuing further training.</p>				

For any queries contact: SMC@sussexpartnership.nhs.uk

Figure 26: SMC booking form for 2014 mindfulness Master classes (2014)

Figure 27 below shows the research poster of a (2015) feasibility study and pilot RCT for Mindfulness-based Self Help (MBSH) below evidences the priority being given to staff-wellbeing within the Trust;

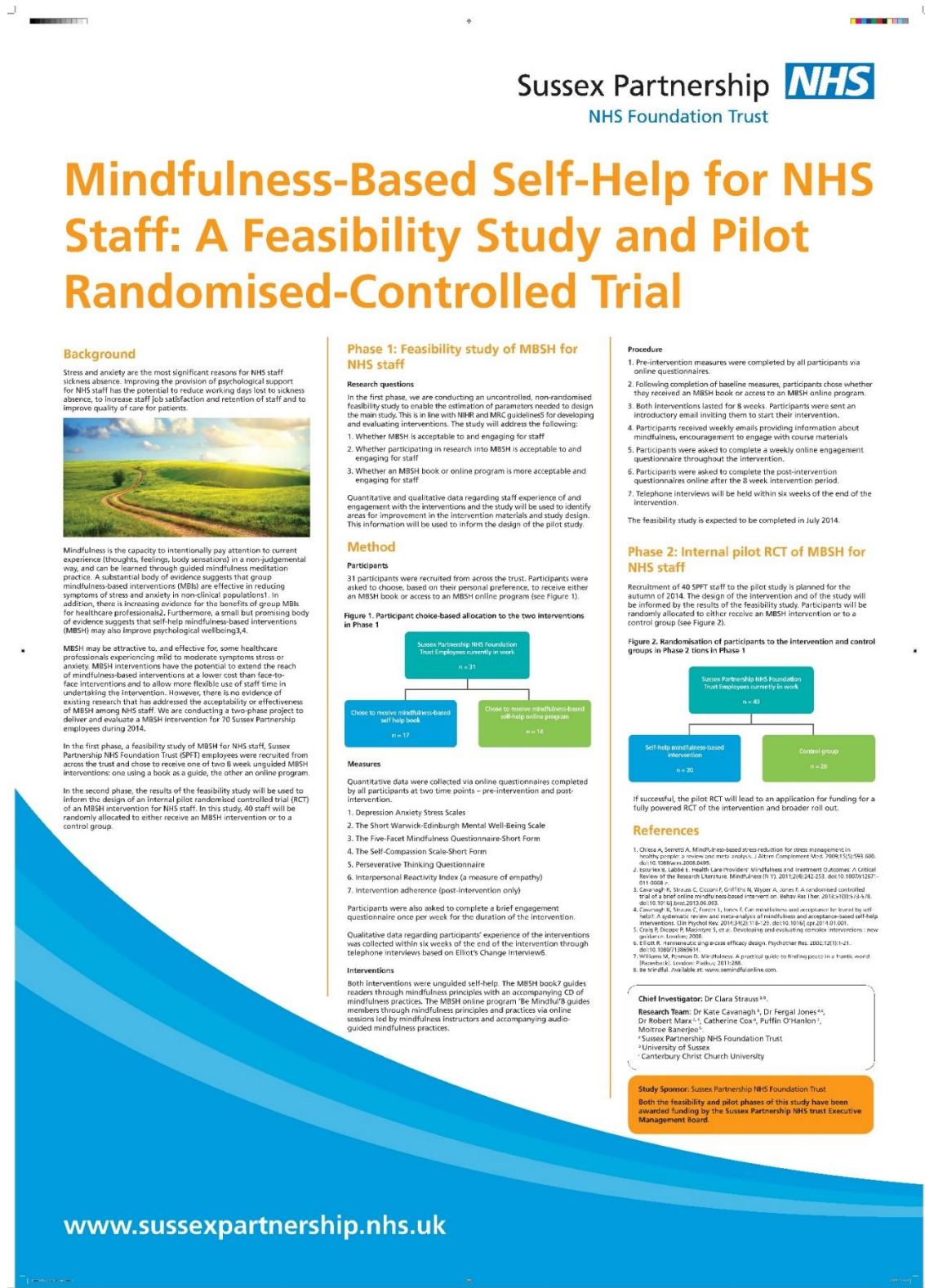


Figure 27: Research poster of SPFT 2015 feasibility study and pilot RCT for Mindfulness-based Self Help (MBSH) (SPFT library (2015b))

Holding regular conferences with interested stakeholders (whose attendance is encouraged by the offering of free places) are evidence of another specific mechanism to maintain the long-term value of MBIs. Figure 28 below shows the 2014 SMC mindfulness conference that took place at the SPFT Research and Development building.



Figure 28: SMC mindfulness conference (SPFT library 2014a)

▪ 6.2.2 'Beyond the fluffy': framing and targeting

The second means identified of maintaining the value base of MBIs over the long-term is by re-assessing the way this therapy is framed and targeted to potential users with the aim of broadening the demographic of those who could potentially benefit.

In tackling the predominance of a typical MBI demographic (Ernst 2000), SPFT manager Kath suggested that *'you need to segment the population, and it probably needs to be packaged, sold in a slightly different way (.) you know, how do you get, how do you get 40 year old men coming along to this?'*. GP Eleanor suggested an additional benefit to the segmenting of the potential user population being the cost-effectiveness of MBIs if targeted to the right user group, in that this group would go on

to use less NHS services¹¹⁶.

When asked how they would explain or attribute the popularity of MBIs, one response to the online survey stated:

Mental health staff are interested in mindfulness at the moment. There has also been a lot of psychological research literature published in recent years regarding its efficacy, and this may have a knock-on effect on service user views. It is also possible that framing mindfulness as skills-based workshops rather than treatment might help to normalise attending mindfulness groups and make them more appealing to individuals.

The implication was made here that MBI attendance may be normalised if courses are framed as skills-based rather than specifically for those who need ‘treatment’.

Community MBI participant Daniel also argued that for courses to be called ‘mindfulness’ rather than ‘meditation’ was itself an attempt at framing to avoid putting off those who would not sign up if they saw that form of language, a way of trying to make it more secular; open for everybody¹¹⁷ (an interesting parallel being drawn here between secularism and openness):

They don't know that most of the time, but I think that is, there's just something (.), and for me, ultimately, that is, that is a spiritual thing, for me, that's a yearning for something more than just our apparent reality. Um, that's not I think necessarily the way it needs to be seen, I don't know whether everyone would agree with that, but that's what makes sense to me...

I mean I say, this is like, you know, if you wanted to run a race, or if you're preparing for an exam, you're preparing your mind in a certain way (.) and this is just an example of that. To try and demystify it. (.) You know, you know, it's not about hippies. It's not, it's not about smoking dope and sitting around and making daisy chains and all the rest (.), this is not what (.), and I think, because for a lot of people the word 'meditation', I mean it's increasingly becoming part

116 Concurrent questions then arose including how to manage the message given to the public, the language to use, the form the promotion of MBIs should take (poster, leaflet, online, TV, face-to face recommendation), the settings where promotional materials would be distributed, and to which demographic they should be focused. In terms of which demographic to focus on, the answer in a broad sense would be those with no previous contact with Buddhism, meditation or mindfulness on their previous sphere of reference. Previous literature and data suggests that this population would include those from a poorer socio-economic group, ethnic minorities, and those out of work (following the productivity focus of key stakeholders) (Ernst 2000).

117 This was an intention in Kabat-Zinn's original framing of the MBSR course in 1979 (Mindful Living Program 2015). Kabat-Zinn has argued for the benefits of mindfulness practices to ‘people in Western society who might be unwilling to adopt Buddhist traditions or vocabulary’ (2000 cited in Baer 2003: 125).

of everyday language but, people have very strong connotations to it.

MBI participant Mark made a comparison between the position and acceptability of MBIs and mainstreaming of acupuncture:

I, I think it's, it's like acupuncture, I think the more it's (.), the more it becomes mainstream the more acceptable it becomes as well and the more people'll say 'oh yeah I know...'. Acupuncture's now available on the NHS I think or, certainly in China it's just considered to be, if you're going to train to be a doctor in China, you're going to learn acupuncture. And I think it's a bit like that really, one of those emerging ones that sort of works and I think some of those fall by the wayside, and some of those, er, some of those old systems can fall by the wayside but I think generally they tend to kind of work their way up.

Mindfulness teacher Izzie chose to pursue a secular route with the aim of making MBIs more accessible for those who may have thought Buddhism to be 'some sort of weird religion that they have to sign up to and they may end up doing all sorts of weird bowing and chanting and who knows what, and actually they can get the benefits of the meditation without (.) without the rest of it being, being present'. Mindfulness teacher Chris commented on the reframing taking place as a result of the mainstreaming of MBIs:

My guess is that, you know, given that there's a lot more mindfulness courses available now, and a lot more people taking them, that, that kind of image of meditation as being something sort of religious or, new age, or, erm, kind hippy or, or a bit flakey, you know, is being countered by the way that mindfulness is being presented. Er, erm, and, and researched and, and offered.

In terms of the countering of fears of misrepresentation of MBIs as 'hippy' beyond the Trust; the '.b' programme website significantly feels the need to state; 'what .b isn't: boring, hippy, yoga, religious, therapy' (Mindfulness in Schools 2015). This intervention began as a course for secondary school children, and has now been adapted for younger children and for the wider educational community, including parents and teachers, with potential implications for the broadening of this intervention as a preventative strategy. As mindfulness teacher Chris stated:

Given that there's a lot more mindfulness courses available now, and a lot more people taking them, that, that kind of image of meditation as being something sort of religious or, new age, or, erm, kind of hippy or, or a bit flakey, you know, is being countered by the way that mindfulness is being presented. Er, erm, and, and researched and, and offered.

The framing of MBIs within clinical encounters was another issue raised by GP Margaret, with evidence here of learning from her own clinical experience, as well as effective means of conveying the evidence for a balanced approach to pharma and

non-pharmaceutical approaches:

How do I use it?...What I would say is that the best outcomes come when people use a mixture of medication and um, some other form of therapy. Um, yeah so I talk to them about the evidence (.). Some people don't want to take pills, some people don't want to do psychotherapy, and I say 'the evidence is best if you can have a go at both (.), however if you only want to do one we'll do it', but we've tried, and usually with these people you've tried this pill and that pill and-, takes a long time to test that pill, 6 weeks at a minimum (.), so by the time you've tried three and they're still miserable, you know, that's over 3 months and that's if you-, very few GPs change medication that fast¹¹⁸.

Counter in some ways to discussions in Chapter 6 of fears of dilution and quality control, the value of MBIs was also imagined as flexible in its application. Clinical psychologist Matthew highlighted that MBCT was a protected term whereas mindfulness was not; *'I mean I'm not MBCT trained but I'm (.), I, I, you know, nobody's going to tap me on the shoulder and say 'you can't run your mindfulness group' because it's (.), you know, there, there aren't those kind of safeguards, around it'*. He argued that for this protection to happen would mean individual Trusts implementing their own safeguards. A balance may be needed between having an organisational strategy and brand protection, and not inhibiting work that might be benefiting individuals but not adhering to the strict quality control.

Highly cited mindfulness literature has argued that MBI course attendance along with regular practice, to affect the mental and physical wellbeing of that individual, but that this effect will only be sustained if regular practice is continued post-course (Kabat-Zinn 2011, 2013; Williams & Penman: 2011; Segal et al 2013). The third means identified in the data for maintaining the longevity of both value and cost-effectiveness was appropriate follow-up support. SPFT is recognising that sustained mindfulness practice is important for clinical value, so try to provide follow-up support sessions for staff and patients who have previously attended an MBI. The drop-off of personal practice following the end of the structured course, feelings of loss following the end of the M4V trial, and the popularity of follow-up sessions offered by MBI teachers, all highlighted the need for this support¹¹⁹. There is thus a concurrent need to prevent relapse,

118 The speed at which GPs change their prescribing decisions relates to discussions in the previous chapter on clinician responses to innovation.

119 On-going aspects of the mindfulness teaching governance criteria and good practice guidelines (GPG) (Mindfulness Teachers UK 2015) – in particular for regular personal practice, supervision and continual professional development – also underscored the need for further support for after the ending of a formal course. Some of those in the Sussex teacher-training scheme supported the idea that support structures could be set up to continue to support their on-going development (Marx et al 2013).

attempt to avoid the need for ‘booster sessions’ following the end of a standard 8-week MBI, and focus on sustaining long-term behavioural change. Appendix 14 shows the current post-MBI support being offered across Sussex, and other forms of follow-up support identified in the data as helpful to MBI course participants alongside the drop-in sessions provided by the Trust (see Maps 1 and 2 of current provision being offered in Sussex in Appendix 11). As can be seen from the map, support is currently concentrated around the Brighton & Hove area, with corresponding implications for access of services for diverse demographic not living in this area.

Of relevance to all the specific mechanisms suggested above, contextual restrictions within Sussex raised in the data are now explored in more detail.

- **7. Contextual constraints**

An overwhelming 98% of clinician survey respondents thought MBIs should be offered to ‘*Everyone According to Need*’¹²⁰. This position was supported by SPFT Manager Kath who saw mindfulness as ‘*something that is worthwhile exploring the clinical benefit of, in a range of areas, but something that everybody should have access to, should be open for everybody. I’m not sure there’s any evidence that it’s detrimental for anybody (.)*’. This argument fits with the ‘*MBIs do no harm*’ position taken by champions of this approach (Heaversedge & Halliwell 2010; Kabat-Zinn 2011).

Arguments for equity of access in the data have obvious implications for funding, which is fundamentally required for evidence for the efficacy of MBIs to be translated into practice in terms of service provision. This study explored the experiences of its informants in terms of the fit between the expectations and hope in this intervention in the context of the realities and ‘situatedness’ of MBIs in the context of SPFT, and situations in which expectations may need ‘re-tuning’ as in the case of the M4V trial. As set out in Section 4.2, awareness of the ‘mangle of practice’ within Sussex was evident in the data. Rachel was also unsure about levels of provision in the future as most courses are self-funded, so the ‘patient’ pays. This highlighted both the ‘value’ of courses but also the disparity between those able to pay privately and those who cannot. Another teacher Chris also highlighted that provision was still sparse compared to the number of people he believed might want to attend and could benefit, and all

¹²⁰ These respondents were made up of NHS clinicians who were probably aware of difficulties in broadening the scope of current provision within the current economic climate, but were responding in terms of an ‘ideal world’ scenario.

teachers interviewed had substantial waiting lists for their courses¹²¹. GP Eleanor also discussed the shortage of funding and the necessity of provision at the delivery end:

Yeah (.) I think there is a momentum, certainly in London there are a lot of GPs who are aware of it, but um, you know I think there needs to be the services available for people too, and it has to be reliable for it to catch on really, and funding needs, you know, there's no funding for anything right now! ((laughing)). And patients also don't fit into perfect boxes um, you know, it requires quite a high level of literacy um, so there's all sorts of barriers (.), but I do think it could help quite a few people.

These arguments reflect discussions in the literature on the degree to which IM - as represented by the incorporation of MBIs into mainstream health services - addresses inequality. Gale (2014) has argued that integrative approaches aid in maintaining colonial and modernist structures, whilst also exacerbating social inequalities instead of challenging public health approaches (Givati 2012). This can result 'in a 'passive' rather than 'active' form of consumerism in integrative medicine' (Gale 2014: 811).

A first step in widening take-up of MBIs may be to meet existing recommendations through NICE for the treatment of recurrent depression (Halliwell 2010). The expansion of MBIs could also be led through the Improving Access to Psychological Therapies (IAPT) programme, whose main aim is 'to support Primary Care Trusts in implementing NICE guidelines for people suffering from depression and anxiety disorders' (ibid: 94). However, mindful of the materiality of limited funding, SPFT manager Sue discussed difficulties in meeting the costs of implementing existing NICE guidelines through talking therapies, within an NHS keen to have 'small cheap packages of interventions that are effective' in the current economic climate and the 'inherited commitments' of the IAPT programme (Summerfield & Veale 2008; Clark et al 2009).

The quote from SPFT manager Kath below brings together several of the concerns of this study, in particular the role of evidence in persuading stakeholders who are sceptical about MBI provision as a core activity of a mental health trust through a return to the regime of truth:

Um, (.) I mean I think, culturally there are some challenges, to get over, um, you know, whether or not people would see a specialist mental health trust core business delivering mindfulness (.), um, but then I think the results speak for

121 The disparity between need and provision was supported by the provisional report from the Mindfulness All Party Parliamentary Group (The Mindfulness Initiative 2015).

themselves. So, I, I think, as we develop it, its just really important we get an evidence base behind it, and we can evidence, not just in terms of the outcomes, clinical improvement or wellbeing, improvement of wellbeing, but also return on investment as well. I think the challenge for us implementing it sometimes is, um it can, sort of, the groups is good, but, its, its just getting that evidence I think to convince people about (.) actually this is where we should put our resources (.) or focus our staff time.

In terms then of the current 'situatedness' of MBIs within Sussex, the screenshot in Figure 29 below shows an article discussing the achievements of the SMC and was taken from Issue 5 of SPFT's Research Magazine (Sussex Partnership Research Magazine 2015). Significant is the use of language regarding working within tight financial constraints of the new Chief Executive of the Trust, Colm Donaghy. This article also evidenced the diverse agenda of 2014 and different attempts to consider MBIs; extending the provision of follow-up support, the application of MBIs for young people with long-term mental health conditions.

Sussex Mindfulness Centre Conference September 2014

We had another full conference at Sussex Education Centre. Colm Donaghy, Chief Executive, gave the welcome address.



"We are keen to ensure, particularly in an environment of tight financial constraints, that we support our staff in providing wellbeing and mindfulness. This year seven mindfulness groups have been run for staff and have been oversubscribed. I'm delighted to see so many people take the time today to find out about the Sussex Mindfulness Centre and look forward to seeing how it expands and grows while keeping its roots very much in Sussex."

Keynote speaker Chris Cullen talked about 'The Mindfulness Initiative in Parliament'.



A review of the mindfulness programme that has been running in Parliament since Jan 2013 and some of the policy initiatives that the All Party Parliamentary Group on Mindfulness is developing alongside this. See more about this on page 6.

Dr Clara Strauss and Dr Robert Marx outlined the developments of the Sussex Mindfulness Centre over the past year, where research has shaped implementation of mindfulness within the Trust for both patients and staff:



- Increased provision of mindfulness groups for patients
- Increased provision of mindfulness groups for Trust staff
- Extended access to follow-on provision: day retreats and drop-ins

Dr Lana Jackson talked about mindfulness for young people with long-term conditions.



Her team co-created the adapted mindfulness-based cognitive therapy (MBCT) course, as a six-week programme for young people in 2011, which has been evaluated and adapted over time. Feedback from the young people who have taken part shows promising results.

There was also a live discussion from people who had taken part in a mindfulness group.

Why mindfulness?

*"Self-compassion is the biggest struggle, but mindfulness has changed my life. I was a copier until one day I began to physiologically malfunction. A GP suggested CBT and then mindfulness. Now my day is 90% mindfulness, which has made me more **compassionate to myself** and better at my work. I cannot imagine a life without mindfulness, so I'm very grateful."*

Figure 29: Issue 5 2015 SPFT Research magazine article discussing the achievements of the SMC (Sussex Partnership Research Magazine 2015)

This publicity from 2014 can be contrasted with the 2015 SMC conference and the narrowing of claims made to a focus on compassion. The promotional poster for the 2015 SMC Mindfulness conference is shown in Figure 30 below, with the choice of keynote speakers a significant development from previous years in the sense of the policy buzz words of mindful leadership being emphasized along with compassion in terms of its relationship to health and presence in healthcare education. These areas of focus reflect discussion in this study on the importance of managerial buy-in as well as placing MBIs as part of the current emphasis on compassion in the NHS.

Sussex Mindfulness Centre 2015 Conference: 'Compassion'

18th September 2015, 9.00am-4.30pm

Friends Meeting House, Ship Street, Brighton

Who is the conference for?

Those interested in mindfulness-based and compassion oriented work in organisations, clinical practice and research

Purpose and Overview

We would like to warmly invite you to the SMC's 3rd annual conference.

The aims of the conference are to:

- 1) Explore the development of compassionate culture in health care organisations
- 2) Discuss compassion-oriented practice and research with NHS staff and service users
- 3) Present other innovative adaptations of mindfulness practice

Keynote speakers

- **Prof Michael West**, King's Fund and Lancaster university: 'Mindful Leadership for Cultures of Compassionate Care'
- **Andy Bradley**, founding Director, Frameworks 4 Change: 'The Relationship between Compassion, Health and Happiness'
- **Philippa Spicer**, Managing Director, Health Education, Kent, Surrey, Sussex: 'Compassion in Health Care Education'.

Plus SMC speakers on innovative developments in mindfulness-based clinical care and research.

For more information, visit <http://www.sussexpartnership.nhs.uk/day-retreats-and-drop-ins> and to request a place at this event,

contact: smc@sussexpartnership.nhs.uk

Tickets cost £75.

Free places available for Sussex Partnership staff, students and service users.

Figure 30: Promotional poster for the 2015 SMC Mindfulness conference (SPFT library 2015a)

Following from the recognition of the role of compassion within SPFT, and earlier reflections on how NHS staff are made, supported and imagined, this chapter now draws some conclusions regarding the future of this intervention.

- **8. Conclusions: a hopeful future?**

The valuation agenda is in itself a negotiated and a social practice. Valuations appear to be performed in almost every sphere of life (Helgesson & Muniesa 2013), and are processes that take multiple forms, and outcomes of collective and relational efforts. In this chapter I have shown how local actors negotiated a field in which different valuation practices and values were overlapping and sometimes contested.

Cost was presented as a version of the regime of truth by respondents to this study, as well as its pursuit in the sense of *doing* evidence work and complying with evidence-based guidelines set out by NICE. NICE assign a particular value to different therapies in the form of QALYs, but the question of an appropriate approach to funding decisions raises questions about the role of economic analysis and qualitative research, as well as social value (Curtis 2012). A growing body of published work supports the cost-effectiveness of MBIs, and difficulties in justifying the cost-effectiveness of MBI provision were explored as well as questions over who should meet these costs. Cost is strongly linked to group delivery, and then evidenced as shown above – and in theory evidence of clinical effectiveness for medically defined groups and conditions.

At organizational level however, the cost argument is not enough, and an optimism and sense of positive feeling allows for broader claims to be made for non-clinically defined groups. Compared to the opinion leader literature discussed in the previous chapter, the sociology of expectations characterise and explain the behaviour of innovators in an organisational context, both in Sussex and nationally, the way they proceeded with a sense of the pitfalls and promise of bringing something new to the NHS, and the creation of an atmosphere of hope qualified by realism. A key aspect of the regime of hope was the emotional investment in MBIs which followed from stories about the personal benefit experienced, rather than formal knowledge claims.

Putting a value on MBIs is more complex than just a distinction between ‘economic’ and ‘non-economic’, and data highlighted the importance of measurement and who defines the outcomes used, particularly as the meanings of MBIs are multiple, a polyvalence which can become problematic when attempting to evaluate this therapy.

MBIs help in the articulation of alternative values which were vocalised by informants in this study: these values being compassion, acting against stress, and quality of life from the user perspective. The M4V trial provided a promising example of the value of group-based interventions for hearing distressing voices (HVG), SU-defined outcomes, and the value of qualitative research in drawing attention to the above. Claims for the value of MBIs by taking a long term perspective with a corresponding focusing on prevention were also explored, and examples highlighted in which evidence and formal RCT outcomes were secondary to other values-based concerns such as staff wellbeing, compassion, and a focus on children and adolescents.

MBIs occupy a position in both the regimes of truth and hope, whilst 'knowing' (as predicted in the expectations literature) that hype needs to be carefully managed. The need for hope in the future was equally recognized, with respondents very often telling quite personal stories to ground this hope in their personal experience.

The final chapter draws together the key arguments from the study, and discusses the likelihood that the future of this innovation will fulfill the current ways in which it is imagined. Directions for future research are also put forward along with the implications of this study for policy and practice.

CHAPTER 8. FINAL REFLECTIONS

- **1. Introduction**

This final chapter will reflect on the key findings of the study. This study critically examined a particular intervention which has currency, relevance and appeal among the wider population and particular appeal within health service providers, especially mental health services. It considered the expectations, hope, and emotional engagement with mindfulness-based interventions (MBIs), and mindfulness-based cognitive therapy (MBCT) in particular, and contributes to existing MBI literature by exploring existing provision and follow-up support, and reviewing the perceived benefits and costs of incorporating MBCT into a specific health service. In this chapter I restate my research questions and present a summary of the key findings which address these questions. I then consider the practice and policy implications of my findings within the context of the pre-existing literature, and highlight areas for further research.

- **2. Summary of key findings**

- ***What are mindfulness-based interventions (MBIs) and how are they being engaged with and experienced, in particular through mindfulness-based cognitive therapy (MBCT)?***

It was established in this study that MBIs are both an alternative and complement to mainstream biomedicine. A form of both 'integrative' and 'participatory' medicine, MBIs are often delivered in a group setting in which participants are encouraged to find their own understanding of their mental and physical health, and draw upon their own resources to care for themselves. Mindfulness-based cognitive therapy (MBCT) is the form of MBI predominantly used in the UK, and within Sussex Partnership NHS Foundation Trust (SPFT) is used as a packaged, 'treatment' intervention.

Evident in the data was the fluidity and re-invention of the definition of MBIs, at the same time as being endlessly specified¹²². Despite mindfulness as a construct being difficult to define in the literature (Grossman 2008; Grossman & Van Dam 2011), and a

¹²² MBIs can be categorised as a form of CAM, though in context of shifting definitions of what CAM is, this categorisation is neither helpful nor entirely accurate, with MBIs potentially being classed as 'complementary' because they do not fundamentally challenge the authority of biomedicine.

challenge for researchers wishing to specify mechanisms of change¹²³, participants on MBCT courses within Sussex did not appear to find it difficult to express the effect it had on them, often by narrating links between the mind and the body.

This study used MBIs as a case-study to consider the evolving role of emotions within mental health. A working concept of emotion was developed from research literature and applied to the empirical data in order to understand how MBIs were experienced and engaged with. This conceptual framework drew largely from the formative work of Hochschild (1983, 1990, 2012), and defined emotion as both emerging from a biological substrate with both conscious and unconscious bodily manifestations, but also as fundamentally social and shaped and manipulated to conform to socio-cultural norms and demands (Hochschild 1983; Bendelow 2009).

The relationship between mindfulness and emotions has been mainly discussed in the psychological literature in relation to the former's effect on emotional regulation levels¹²⁴ (Feldman et al 2007; Corcoran et al 2009; Hülshager et al 2013) and the treatment for specific conditions such as generalised (Roemer et al 2009) and social anxiety disorders (Goldin & Gross 2010). Following Hochschild (1983), emotions were found to be susceptible to training and management through MBI practice, increasing the ability of course participants to deal with difficulties in day to day life as well as habitual thought patterns. Mindfulness itself does neither condone nor condemn emotional reactions, but focuses instead on developing an awareness of what happens around us and our tendency to react to what happens.

In terms of varied experiences of MBCT, data from interviews with M4V trial participants also brought to light concerns relating to the particular needs that people with psychosis may have (Smith et al 2006). Data describing the experience of the course showed that for those who hear distressing voices or experience panic attacks, a focus on the breath and bodily sensations as encouraged by particular exercises might not be helpful, nor the body be a place of safety to retreat to¹²⁵. The data also

123 Baer's comprehensive review of the effects of mindfulness interventions across a range of clinical interventions stated that the key barriers to empirical research in this area are 'a lack of clear operational definitions of concepts and procedures and the identification of clearly delineated mechanisms of change' (2005).

124 This is a general term that includes; being aware of and paying attention to emotions, understanding and labelling them, and managing our emotional reactions. Poor skills in emotion regulation ('emotional dysregulation') are seen as a central feature of emotional problems (Donahue 2014).

125 Mills argues that for someone vulnerable to psychosis, it is very important that a sense of

showed the participants' own narration of their problems mapped on to what the trial was attempting, as well as the imprint of mindfulness on participants' narration of their experience.

The data suggested that MBIs cannot be engaged with as a manualised intervention, but are rather a discursive product of interactions between the facilitator and course participants, between peers attending courses, and of the subjective interpretations of those exercises aimed at bodily experience. The group format of MBIs is both cost-saving for those running the intervention *and* creates positive feelings amongst many users of the intervention¹²⁶. Difficulties were highlighted however in identifying what happens emotionally within the group, as well as separating the effects of personal practice from the non-specific factors resulting from a regular and supportive group environment. Through the embodied experiences of being in a group therapeutic environment, this data supported relational theories of the biological body (Holmes 2010) as a manifestation of *the social* (as described in Chapter 2). Emotional experience was discussed as integral to wider conceptions of selfhood (Fox 1998). Paying attention to emotions through mindfulness practice can be a way of being more aware of all components of present moment experience, as well as increasing relational understandings within a group therapeutic environment.

As discussed in Chapter 5, one of the founders of the application of mindfulness skills to western medicine, Kabat-Zinn acknowledged the impact of context and inequalities on a person's health and ability to practice, but argued that individuals are always capable of contributing to their own healing, irrespective of their socio-economic position (2013). Despite the strength of this position, the risk remains of creating a division between those with the emotional capabilities to access and practice this

'safe self' be established (2010). The safety of this sense of self is not present if a person transcends their embodied self before it has been grounded or firmly established (ibid), hence the psychoses common in adolescence, and the value of a mindful emphasis on grounding (though will a simultaneous stress on not clinging to much to the thought of an embodied concrete self). Being grounded without being fixed to a permanent or concrete sense of self is a difficult tightrope to walk. Given that psychosis has long been theorised as a breakdown in the basic integrity of the sense of self, the deployment of an intervention that promotes further flight from the ego is a step that should be taken cautiously. These arguments can be contrasted to anecdotal data from my contact with key stakeholders within Sussex that practicing mindfulness will not harm even if does not actively help.

126 MBIs occupy the interesting position of incorporating practices which fundamentally need to be carried out by the individual, whilst its emphasis on group and community do not easily position this intervention as part of the modernisation agenda of making people responsible for their own health (Wilkinson & Gale 2015).

therapy and those who are unable to do so. Many participants were sensitive to existence of this division, along with the impact of socio-economic factors on both on being able to afford to attend MBIs privately, and whether an individual would be accepting of and drawn to mindfulness as a therapeutic option. Mindfulness or meditation being within an individual's previous realm of experience was found to strongly indicate the likelihood of being accepting of and drawn to MBIs. Socio-economic inequalities thus continue to be integral to any analysis of the impact of MBIs on individuals' emotional and embodied wellbeing, with potential benefits of MBIs being structurally conditioned.

- ***Who is promoting and working with MBCT as a form of innovation in Sussex Partnership NHS Foundation Trust (SPFT), and how does this innovation acquire currency?***

In terms of its position within SPFT, MBIs were being used as a strategy by an organisation keen to be receptive to new areas of innovative research, and the Sussex Mindfulness Centre (SMC) has been a central part of the promotion of this intervention. My 'insider status' allowed through collaboration with SPFT permitted me to gain insight into the activities of key stakeholders within the Trust who were pursuing MBIs because they felt them to be worthwhile, as well as questioning and deciding *how* they were worthwhile, whilst juggling different timeframes and agendas. The growth of the concept of integrative medicine demonstrated efforts by medical practitioners to work collaboratively, and MBIs provide an interesting case-study of this process in action. The strategic employment of MBIs by SPFT incorporates the expression of compassion and a specific set of values, as well as taking a particular approach to service user (SU) involvement¹²⁷.

SPFT provided MBI training for staff to then deliver to patients, as well as courses for staff to deal with stress, as part of the same strategy of experiential knowledge generation. The argument was made that specific forms and conceptions of knowledge enabled through MBIs were embodied, experiential, and 'practical' (Fairhurst & Huby 1998; Leonard & Sensiper 1998). SMC's teacher training programme formed a key part of the strategy of champions and opinion leaders for which experiential knowledge was a precursor to interest *in* and practice *of* mindfulness (Armstrong & Ogden 2006). In a

127 When patient's experiential knowledge can be translated into explicitly made ideas or demands, it may be able to improve the quality of biomedical research. This translation however requires an approach to patient participation that currently faces various obstacles.

staged process of involvement with innovation, adhering to the requirements of evidence-based medicine (EBM) and endorsement by NICE helped MBCT to acquire wider or greater currency, which were in their turn reinforced and spread through embodied experiential knowledge of mindfulness practices.

The role played by hope and expectations in mobilising resources (Tran 1998; Borup et al 2006; Gyani et al 2014) was also demonstrated in terms of acquiring funding for MBI provision and training, and garnering stakeholder support, legitimised through RCT evidence. The SMC was made up of enthusiastic individuals who were harnessing that enthusiasm to do research, which also helped narrate the MBI intervention as less 'fluffy'. For those individuals within the SMC who practiced mindfulness personally, this was not just an emotional but fundamentally a *bodily* engagement with mindfulness.

As highlighted in Chapter 2, Barbalet argued that a 'well-developed appreciation of emotions is absolutely essential for sociology because no action can occur in a society (meaning an interactive system) without emotional involvement' (2002: 3).

Organisations such as SPFT (and the team environments and hierarchical structures within it) can be seen as an interactive system, with embodied agency/emotional modes of being-in-the-world wider as 'institution-making'¹²⁸ (Csordas 1994). The effect of MBI practice on the emotional climate within a team or organisation is highly relevant to discussions on the embodied authority of opinion leaders within the Trust.

The popularity of MBCT was largely attributed in the clinician survey to SPFT publicity, and in people seeking ways of managing stress (and *distress*) through many means. Addressing stress was seen as a legitimate platform for publicity on the part of the Trust, primarily for service users¹²⁹. In terms of awareness of MBIs many stakeholders interviewed who had not previously attended an MBI had an existing understanding of mindfulness¹³⁰, though personal experience of Buddhism and meditation were also commonly cited as part of the interest in MBIs.

128 Through work on the 'emotionally expressive body' and the 'means by which these bodies achieve a 'social ontology', praxis and agency' (Williams & Bendelow 1998, 2002; Crossley 2000; Freund 2008) it has become possible to explore institutions in terms of the bodily forms (Williams & Bendelow 1998).

129 From my fieldwork I was also aware of a level of frustration with structural changes within the NHS, and stress experienced in the workplace may also mean a lot of informants choosing 'Disaffection with 'traditional' mental health approaches and ideology' as a response when asked about the reasons for the popularity of this therapeutic approach.

130 Given the demographic completing the survey this was not surprising considering both the promotion of courses through the Trust, and that people answering the survey on mindfulness

The communication of evidence was strongly related to how particular forms of MBI acquire currency. Data suggested that the results of clinical trials also becomes more relevant for everyday practice when it is supported by a consensus amongst peers (Fairhurst & Huby 1998). Factors impacting on referral decisions related strongly to the communication of evidence, exploring the complexities of a clinician being encouraged to act on evidence whilst also taking into account a range of other factors, as well as the unique potential for self-experimentation that MBIs allow¹³¹. Crucially it was not necessary for a clinician to have attended an MBI in order to refer a patient to a course, but those who had were more likely to be sympathetic to this option.

Few patients with recurrent depression and other mental health and/or physical conditions who could benefit from MBIs are being offered them, and it is thus especially important for GPs to know what services are available locally, and build on the current knowledge of the potential benefit of MBIs. Having the time to attend courses in an already busy workload, and knowing a local course of good repute to refer their patients to were also recurrent themes in the data.

The M4V RCT was discussed as the latest application of this innovation within Sussex and an example of 'diagnostic fluidity' in engagement with this approach. The data suggested that the experimental approach of using mindfulness for the treatment of psychosis was worthwhile because there was a degree of uncertainty on the part of both the clinicians and participants on efficacy of this application. The data from this study helped to address this uncertainty.

- ***What are the implications for future mental health policy and practice, both within Sussex and nationally?***

A recent publication of the Mindfulness All-Party Parliamentary Group's inquiry (The

therapies would most likely have heard of the increased publication rate and research being carried out on the efficacy of MBIs.

131 In terms of which form of MBI clinicians would refer patients to, my initial hypothesis regarding referral patterns was that there would only be one or two respondents - if any - who had referred patients to an online course because of the scepticism about the benefits of face-to-face courses as compared to online courses. This was because the majority of people would have heard of MBCT not MBSR so would refer to MBCT courses rather than the latter. I was unclear about how familiar members of the public were with differences between MBCT and MBSR, but expected that members of the health service would be aware of the specific cognitive elements of the MBCT course. Care needs to be taken in drawing conclusions that having been on a course leads to clinicians being more likely to refer in the future, because these individuals may have been more likely to refer anyway.

Mindfulness Initiative 2015) stated that:

The government could further widen access by introducing mindfulness in key public services, where it has the potential to be an effective low-cost intervention with a wide range of benefits. It could also help with the high levels of stress in many parts of the public sector – among teachers, the NHS and police and prison officers, for example – which is leading to a growth in sickness and absence as well as problems with recruitment and retention (2015: 3).

A central implication explored in the data were issues of the valuation and evaluation of MBIs (the valuation agenda in itself being a negotiated and a social practice). Value which was not defined in economic terms was difficult to find in the innovation literature, which has been key in drawing attention to the varied influences on healthcare professional and organisational behaviour (Proctor et al 2009).

Serious mental illnesses (SMIs) are costly to both individuals and society, with the health, social, and financial costs of schizophrenia especially high (Knapp et al ed. 2011). Literature in the sociology of medicine has helped highlight the direct implications of these costs for increasing the provision of evidence-based therapeutic options for groups who have previously been excluded from talking therapies (Pilgrim 2008). Those involved in designing studies of the effectiveness and cost-effectiveness of MBIs need to consider equity of access to the interventions in their studies and how this might affect both the validity and reliability of the data. In a time of rapid expansion of mindfulness research and its applications (Williams & Kabat-Zinn 2011), there have also been calls by supporters of MBIs for more health economics research to make the cost-benefit, cost-effectiveness and cost-utility cases for its wider application (Kabat-Zinn 2013; Edwards et al 2014). Health economists also need to be aware of appropriate research design, and be knowledgeable of interventions being evaluated within specific contexts (Edwards et al 2014). Another central issue in economic evaluation of group-based therapies is that of quantity. If participants on MBIs do not attend all of the sessions (as outlined in the trial protocol), they do not then get sufficient periods of guided practice. This lack can then affect the potential outcomes assessed in the trial as well as the average cost of the intervention (ibid).

Questions of taking an appropriate perspective for healthcare funding decisions are not just technical, but raise fundamental issues about social value, and the role played by both qualitative research and economic analysis (Curtis 2012). In terms of evaluation the very openness of MBIs in terms of their diverse appeal becomes difficult. Despite

efforts to settle on patient-centred outcomes such as those assessed in the M4V trial, subjective wellbeing and emotional experience are hard to capture in short trials, and the argument was made that qualitative research needs to work more to its key strengths to make a more powerful impact on humanising practice in healthcare¹³².

The evaluation of these kinds of interventions is difficult, requiring the use of quantitative and qualitative evidence, and the contribution of sociology to exploration of this area is increasing (Campbell et al 2000), with the aim of providing a 'rich, detailed and highly practical understanding of a complex social intervention', likely to be of much use to managers and policy-makers when 'planning and implementing programmes at a national, regional or local level'¹³³ (Pawson et al 2005: 21).

MBIs were also seen to acquire currency as a creative intervention through the articulation of a particular set of values beyond short-term outcomes as part of the IM agenda. This study proposed that value can be viewed as a bridge between the requirements of EBM in terms of measurable, monetizable outcomes and clinical (often pharma-based) perspectives, and the lived/embodied experience and priorities of users of MBI participants. Mindfulness can usefully be conceived as a link between relationship-centred care (a central aspect of values-based medicine) and EBM, as well as being considered a characteristic of good clinical practice.

Psychotherapeutic innovations, much like physically orientated medical innovations, emerge from hope as well as evidence, for example, a therapy is tried out for X and found to be helpful, so it often makes good sense to consider applying it to Y (hence the diagnostic fluidity of the M4V trial). MBIs were imagined as continuing to expand but emotional investment, expectations and the 'regime of hope' in the future of MBIs was tempered by a realist view of the constraints facing the use and delivery of this therapy. Hope and expectations appeared to be in slight tension within the Trust as a result of the tough funding environment extending (and potentially worsening) into the

132 The utility of qualitative research was also acknowledged by policy-makers as a useful supplement to RCTs, along with the parallel assertion made by the same respondents of the need to persuade those who are sceptical with hard numbers. Not all MBIs studies need be in the form of an RCT. RCTs however are necessary for evidence of the effectiveness of an MBI to be considered by the medical and clinical professions, and Edwards et al recommend they should thus adopt a pragmatic approach accounting for the real-world features of the delivery and uptake of MBIs (2014).

133 MBCT sits at the intersection of growing recognition of the benefits of combining qualitative and quantitative research. Evaluations are not about the labelling as qualitative or quantitative, as there is a need for good critical evaluation in all types of social science (Oakley 2000).

future, with the recognition that hope is also necessary in imagining the future of MBI provision as well as having the energy to make this future possible. Actors in the context of Sussex played with the regimes of truth and hope, roles which require reflexivity and an acceptance of the need to live with a degree of uncertainty. Significant symbolic and material investments in MBIs should thus be reflected upon critically, with a corresponding need to acknowledge that the future is still only available through abstraction and the imagination (Brown 2006). The tempering of expectations can direct attention instead to practical issues regarding the potential of MBIs to enhance clinical practice and patient care (Pickersgill 2011). For expectations and hopes invested in MBIs to come to fruition requires adequate funding, with a central organisational restriction being cost.

Organisational commitment and barriers to implementation were reflected in the study, these included;

- the compatibility of mindfulness and CBT,
- need for autonomy of choice in attending,
- the loss of particular elements of the course as part of the roll-out process,
- the need for trained staff to meet capacity,
- the dangers of practicing *without* a parallel attendance to daily behaviour patterns, and cultural challenges to be overcome

These were all concerns expressed by study respondents. The data also highlighted the specific information which policy-makers need on action to be taken beyond advocating for a particular intervention (Singleton in Mol 1998 86-104; Armstrong 2006; Spyridonidis & Calnan 2011). As gatekeepers to services GP opinion carries a significant weight with both patients and policy makers, and the fact that GPs take a favourable approach towards MBIs gives reason for optimism in terms of increased roll-out.

In terms of the implications of this study for the future, claims for the value of MBIs by taking a long term perspective with a corresponding focus on prevention were explored. Examples were highlighted in which evidence and formal RCT outcomes were secondary to other values-based concerns such as staff wellbeing, compassion, and a focus on children and adolescents, and service user-defined outcomes. MBIs may provide a means to engage with the values that appear to be important in sustaining behaviour change over longer periods of time, and the maintenance of mindfulness practice was highlighted as key in terms of sustaining the value of this

intervention in terms of both cost-effectiveness and personal benefit to the practitioner. For this, adequate follow-up support was highlighted as key, as well as the case for the cost-utility and benefit of investment to be made. SPFT's Operational Plan (2015) for year ending 31 March 2015 stated:

The Board has acknowledged that continuing financial pressure and the on-going need to consider growth and diversification, could impact on quality. It is crucial our services can be both clinically and financially sustainable to secure our long term future. This will require us to think creatively at how we can transform the way we deliver care for people, building on developing new partnerships, exploring models of integrated delivery and the use of digital technology. We will also consider new opportunities to diversify our provision where we have core services and infrastructure established (Sussex Partnership Operational Plan 2015: 3).

Research findings from this study also have policy and practice implications within mental health in terms of influencing debates about priorities for healthcare expenditure, as well as the transfer of evidence into practice.

Challenges continue to be faced in translating knowledge into improvements in health, and in translating research into practice. Transfer of research to practice has been argued to thrive when initiatives 'are given regional strategic support, leadership and funding which enables the development of centralised governance on practitioner training and good practice' (Crane & Kuyken 2013: 252). As scientific knowledge advances, new paradigms may be required for practitioners and researchers to maintain a competitive advantage and competence in the field. Developing specialised electronic information systems such as the *Mindfulness Research Monthly* is one way to bring a synergy to the vastness of current research on human health (Black 2010). The Savoy Partnership agenda for psychological therapies (New Savoy Partnership 2014), and the ASPIRE study (Rycroft-Malone et al 2014) are examples of specific investigation of evidence into practice in mental health and mindfulness.

Primary Care commissioners could also consider how they can best build service capacity. There is a corresponding need to train more staff within these Trust localities, and for these staff to have a sustained level of mindfulness practice. This study thus has implications for investment in staff wellbeing through both the MBI facilitator training programme run through the SMC (for staff as well as patient benefit) and for courses provided specifically for staff. Training organisations have waiting lists and an embryonic system of registration of mindfulness teachers, with a corresponding constraint on the scaling up, and accessibility of, MBIs, though scaling up raises its

own concerns over compromising the quality of delivery (The Mindfulness Initiative 2015).

Lessons learned from staff-group feedback include: that course content needed to be pitched appropriately and the safety of the group given high priority; that groups have a long lead-in time (though the opportunity cost for releasing staff too is tricky in already stretched roles), and that strategic selection of staff should be made for where the approach might be most beneficial (Marx et al 2013). Feedback from training groups also revealed challenges of the partial 'conscript' population, that managers need to know what they are encouraging their staff to go on. MBSR potentially has a higher chance of buy-in due to stressful 'driven doing' environments within the NHS. Feedback indeed showed that an adapted hybrid of MBCT/SR was most popular, with a focus on common issues and use of specific workplace metaphors to make relevant. Ongoing discussions within the Trust (gained through a workshop at the Bangor Mindfulness Conference in Chester 2013) also included lessons that might be learned from the private sector in terms of provision, training and outcome measures. The negotiations needed with managers over the time taken to train members of staff from their teams was a key issue, again highlighting the need for managerial 'buy-in' in the implementation of MBIs within the Trust. As a member of the SMC training team commented at a National Mindfulness conference in Chester (cmrpconference.com: 29.8.15); *'managers should put their own oxygen-masks on first, start at the top'*¹³⁴.

• 3. Directions for future research

This study has implications for a sociology of embodiment, which takes the lived meanings and experiences (both of the practitioner and those studied) seriously, in health services as elsewhere (Williams & Bendelow 1998). Mental health services require a fundamental understanding of what it is to be a person and accounts of the experience of lived personhood (McMillan & Gillett 2005), an embodied sociology is

134 The rationale behind this program was that as MBCT becomes more widespread across SPFT, the need for further training places for SPFT staff on mindfulness courses may reduce and become more focused on areas where provision is absent. The systematic registration of mindfulness teachers is still in the early stages of development, leading to difficulties in members of the public in assessing the credentials of teachers. Progress is being made on this with the UK Network of Mindfulness-Based Teacher Training Organisations (Mindfulness Teachers UK 2015) which has produced Good Practice Guidelines. However progress towards clear governance of mindfulness trainers is now seen as a priority (ibid).

necessary in bringing these concerns to the fore¹³⁵. Growing attention to mental health and well-being is to be welcomed, and with the proliferation of research of MBIs over the past 25 years, a broad knowledge base has been established about the phenomenon of this intervention and its consequences. Despite increasing support from empirical studies for the beneficial effects of mindfulness practice however, both conceptual and methodological conundrums remain relating to empirical studies of this intervention (Davidson 2010).

The effects of mindfulness practice on the emotions, and the neural mechanisms that underlie these benefits warrant further investigation, though the increase in publications in this area of neuroscience give reason for optimism (Chiesa 2013). Following from discussions of consciousness in this study; important areas for empirical and theoretical development include further investigation of mindfulness as a 'quality of consciousness', which Brown et al have argued 'will necessitate more refined measurement, including experimental and other laboratory-based paradigms to permit closer study under controlled conditions' (2007: 280). Other recommendations for future research in the literature include the further integration of mindfulness into psychology and other clinical uses (Shapiro & Carlson 2009), the development of the use of formal vehicles for assessing MBI teaching competency (an evidence base added to by Marx et al (2013) from the SMC teacher training programme), and the value of examining self-compassion as a potentially important mediating mechanisms in future studies (Shapiro et al 2005).

In the current multi-million pound (ASPIRE) programme, the *Promoting Action on the Implementation of Research in Health Services* (PARIHS) framework is being used in which successful implementation is achieved through a combination of evidence, context and facilitation¹³⁶ (Rycroft-Malone et al 2014). The similarity of approach between my methodology and ASPIRE (which was not funded until *after* the start of this PhD) indicated this area of research to be both topical and of relevance in terms of an in-depth focus on the interactions within a specific geographical and organisational arena.

135 Further research that included both clinical and user-defined outcomes might also contribute to a more recovery-focused approach, as well as the evaluation of application of theories of social models of recovery and SU to the real lives of service users.

136 ASPIRE's Implementation Plan will be developed with the aim of a tailored and flexible approach for use by GPs, service managers and clinicians, to maximize the impact of this study through practical resources (Rycroft-Malone et al 2014). Similar themes emerged from my study as in Phase One of this trial.

High-quality empirical studies and RCTs of the mechanisms of mindfulness in medicine are still needed (Ludwig & Kabat-Zinn 2008), with more pilot projects incorporating good research and evaluation, building on the results of the ASPIRE Implementation study and field of implementation science. In terms of the areas of research it is also important to focus on demographic contexts less known for their receptivity to 'hippy'/'flakey'/'fluffy' therapies than Sussex, particularly Brighton & Hove. Well-designed evaluations using cost-benefit analysis, alongside future trials, also offer the potential for further insights into the potential costs and benefits of MBIs, insights which may have the ear of health care commissioners and policy makers¹³⁷ (Edwards et al 2014). Crucially, consideration needs to be given to broadening access to MBIs for individuals with long-term health conditions, and in improving its reach to a broader population (The Mindfulness Initiative 2015), as well as building on current work of SPFT on widening this participation.

As part of an integrated medicine agenda, 'Health and Wellbeing Boards now have duties to encourage integrated working between commissioners of services across health, social care, public health and children's services, involving democratically elected representatives of local people'. In the future local authorities will also be expected to work on a closer basis with other healthcare providers, agencies, and community organisations. Primary care practitioners are relatively isolated and therefore can provide a valuable source of knowledge on how new information engages with professional practice. By examining how these individuals acquire knowledge and change their behaviour, future recommendations for the awareness, promotion and utility of MBIs could be further developed. The interaction between champions, opinion leaders remains poorly understood, as well as the changing nature and reorientation of professional norms, and their role in improving clinical effectiveness and raising public awareness (Locock et al 2001; Khoury et al 2013). Growing research into emotions within organisations could also build on that of US programmes to create a culture of mindful awareness within organisations. These aim to create health and resilience for both clinicians and patients (Luchterhand et al 2015).

In terms of sustaining the clinical value of mindfulness practice, more research is needed to explore factors which facilitate the maintenance of long-term mindfulness

¹³⁷ Challenges to health economists include the more effective means to capture ways that MBIs help participants to build resilience, as well as to disseminate this evidence effectively to allow policy makers to judge the value of MBIs' potential contribution (Edwards et al 2014).

practice and behavioural change (Edenfield & Saeed 2012). We saw that a sense of community can help to form a supportive environment for sustaining mindfulness practice, and that in the largely secular context of Sussex, efforts are being made to create communities around practice¹³⁸. In considering expanding MBI provision, promotion was discussed as being more than the passive dissemination of information (Bero et al 1998), needing to be supported by 'reinforcing strategies' (Davis et al 1995). As well as preventative targeting of populations currently not using MBIs, these reinforcing strategies could include reconsidering the framing of this intervention. Promising current developments also have the potential to increase the reach of MBIs and their potential value as an intervention to diverse audiences; including digital delivery of courses and wider availability of mindfulness books. Further study is required on the efficacy of these methods, with corresponding concerns that individuals who only have access to digital resources have less opportunity to access the benefits of teacher-led group classes (The Mindfulness Initiative 2015).

- **4. Concluding comments**

MBCT, as well as MBIs more broadly, were useful as a prism within which to examine innovation, evidence and the management of 'stress' in both UK society as a whole and within the particular institution of SPFT. This study focused on the lived experience of those who had experienced the MBI intervention, as well as wider stakeholders who engaged with it across a specific institutional and geographical area.

MBIs were not argued to be a one-stop solution to either mental or physical health problems. However despite limitations in the mindfulness literature, findings to date have shown that sustained use of mindfulness practices can lead to more adaptive and flexible responses to mental distress in many forms (Kuyken et al 2015).

As discussed in Chapter 3, Guarneri argued that significant cost savings and health benefits could be brought about by utilising integrative healthcare strategies for those with recurrent depression, as well as preventive strategies to support wellness in the general population (2010). MBIs were argued to be just part of such an integrative as well as preventative approach. MBIs however require embedding through a rigorous

138 The UK Network for Mindfulness-based Teacher Trainers outlines good practice guidelines for training and clinical supervision (Mindfulness Teachers UK 2015). Mindfulness trainers in this study sought to help people sustain their personal practice. This is an area where mindfulness trainers might further co-operate (as already occurs within SPFT), and may reduce some of the pressures of providing that support individually.

evidence base, delivery infrastructure, and culturally through sustained practice. All of these aspects were necessary as a basis for the 'cautious optimism' expressed in the data.

Integrating the phenomenology of complex mind/body interactions as experienced by participants on MBI courses has contributed to understandings of emotions as experienced and displayed, and as both historically and socio-culturally grounded. This study did not try to replace the biological view of the body but to explore it taking a wider perspective. Moving beyond the dominance of binary divisions such as; biology versus society, rationality versus emotion, and processes of medicalization and demedicalization, Williams has suggested 'ways forward through a commitment to the emotions, their relationship to mental health and to rationality and, more generally, to their 'fate' in late 20th century Western society' (2000: 559). The potential role of MBIs in adding to this area of study is an exciting one, adding to the theorising '*from* rather than *about* bodies as lived entities' (Williams & Bendelow 1998: 209). These findings suggest the biomedical paradigm needs to be broadened to include a developmental model of embodiment to increase understandings of how body-awareness enhances therapeutic work (Mehling et al 2011). Hence emotions are productively conceived of as not just mind/body but mind/body/society. It is hoped that this study can play a part in efforts to 'reinsert emotions more positively into current sociological debates on (mental) health and social life' (Williams 2000: 151).

Of interest in this study was that the data did not suggest that biomedicine adequately captures either the nuanced relationship between the mind, body and emotions, the social dynamics that lie behind health-related behaviours, nor the diversity of values and experiences of users of healthcare services. As well as acknowledging the need for evidence, persistent questions were raised as to what counts as evidence, as well as highlighting the need for nuance and theoretical diversity in the field of CAM. As Gale has suggested, a fruitful area of enquiry is interdisciplinary working (through which we can understand the mechanisms of CAMs) and an increase in creative methodological approaches focusing on embodiment (2014). Though biomedicine may not have concede much in terms of authority, Gale argues that 'there may be scope for sociologists working in a critical friend role with activists globally who are demanding health systems to be more responsive to their health needs' (2014: 816). Western societies continue to frame personal and social problems as medical in nature, and both self-help and CAM have been identified as encouraging as well as resisting medicalization (Barker 2014). These critiques can be applied to MBIs; however the

data did not support Barker's argument. The dualistic language applied to CAM and biomedicine can mask the potential for both to change, and the case of MBIs has shown that CAM, like conventional medicine, can change and evolve, with a corresponding need to challenge the assumptions that underlie many debates in this arena.

The Western medical model could benefit from further integration of the philosophies and practices of healing systems which complement biomedicine. The relationship between Buddhist psychology and Western therapeutic approaches is a complex one, highlighting the need for a multi-cultural psychological science and nuanced reflections on the means to psychological and spiritual development. The meeting of globally diverse epistemologies and 'commensurability of paradigms' (Ingleby 2004: 25) has highlighted the need for ontological reflexivity, and points of divergence and intersection between studies grounded in different epistemologies can shed light on key theoretical areas in this study including the relationship between the mind and the body and what can be learned from embodied experience. Data from this study supported this integration of different epistemologies through the integration of MBIs into mainstream health services, whilst also highlighting complexities of this integration within a largely secular organisational and cultural context in terms of how to frame and promote this therapy.

Despite government emphasis on the importance of context, partnerships, and values made in the National Service Framework for Mental Health (National Service Framework for Mental Health 2015), the stated commitment to address connections between poverty, unemployment, and mental illness has not had a concrete impact on disadvantage and social exclusion in real terms (Bracken & Thomas 2001). The articulation of alternative values may not be enough in the face of the impact of contextual constraints on MBIs implementation, in particular limitations on funding within the health service. Even if a psychosocial intervention such as MBIs has an evidence base and compelling aims, has been recommended by NICE, and the cost-effectiveness argument made, its value is determined by its accessibility and availability in the health service (Crane & Kuyken 2013). Take-up of MBIs remains reliant on the availability of places, and access to, the knowledge of how to use, and the ability to pay for courses both face-to-face and online. Within the wider truth of high need and constrained budgets, the future of MBIs thus remain dependent on several factors; the cost-effectiveness case being made for sustained or increased MBI provision, policy-makers having access to intelligible applications of MBIs, the effective

translation of evidence into practical implementation strategies, and the integration of VBM and meaningful service user involvement with EBM in terms of outcome measures within future RCTs.

By combining empirically tested conceptual models for the therapeutic benefits of MBIs with a rigorous evidence base for the application of this intervention for particular conditions, MBIs may continue to grow in popularity as both a clinical intervention and self-care strategy.

BIBLIOGRAPHY

- Abba, N. (2008) Responding mindfully to distressing psychosis: A grounded theory analysis. *Psychotherapy Research*. 18: (1): 77-87.
- Aggs, C. & Bambling, M. (2010) Teaching mindfulness to psychotherapists in clinical practice: The mindful therapy programme. *Counselling and Psychotherapy Research*, 10(4), 278-286.
- Alderson, P. & Goodey, C. (1998) Theories of consent. *British Medical Journal*. 317(7168): 1313-1315.
- Alonso, Y. (2004) The biopsychosocial model in medical research: the evolution of the health concept over the last two decades. *Patient education and counselling*, 53(2), 239-244.
- Anderson, S., & Brownlie, J. (2011) Build it and they will come? Understanding public views of 'emotions talk' and the talking therapies. *British Journal of Guidance & Counselling*, 39(1), 53-66.
- Andresen, J. (2000) Meditation meets behavioural medicine. The story of experimental research on meditation. *Journal of consciousness Studies*, 7(11-12), 17-74.
- Anthony, W. A. (1993) Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychiatric Rehabilitation Journal*, 16(4), 11-23.
- Archer, M. (2000) *Being Human - The Problem of Agency*. Cambridge University Press: Cambridge
- Armstrong, D. (1995) The rise of surveillance medicine. *Sociology of Health and Illness*, 17(3) 393-404
- Armstrong, D. (2006) Embodiment and ethics: constructing medicine's two bodies. *Sociology of health & illness*, 28(6), 866-881.
- Armstrong, D. (2014) Actors, patients and agency: a recent history. *Sociology of health & illness*, 36(2), 163-174.
- Armstrong, D., & Ogden, J. (2006) The role of etiquette and experimentation in explaining how doctors change behaviour: a qualitative study. *Sociology of health & illness*, 28(7), 951-968.
- Armstrong, D., Reyburn, H. and Jones, R. (1996) A study of general practitioners' reasons for changing their prescribing behaviour, *British Medical Journal*, 312, 949-52.
- Arndt, J. (1967) Role of product-related conversations in the diffusion of a new product. *Journal of marketing Research*, 291-295.

- Attride-Stirling, J., Davis, H., Markless, G., Sclare, I., & Day, C. (2001) 'Someone to talk to who'll listen': addressing the psychosocial needs of children and families. *Journal of community & applied social psychology*, 11(3), 179-191.
- Audio Dharma six week mindfulness course (2014). Available at: <https://sites.google.com/a/audiodharmacourse.org/mindfulness-meditation/week-3-emotions> (Accessed: 13.6.14).
- Avis, M. (2003) *Qualitative Health Research*. London: SAGE.
- Avis, M. (2005) Is there an epistemology for qualitative research? in Holloway, I. (ed.), *Qualitative research in health care* (pp. 3–16). New York: McGraw-Hill
- Ayers, S. L., & Kronenfeld, J. J. (2010) Using factor analysis to create complementary and alternative medicine domains: an examination of patterns of use. *Health*: 14(3), 234-252.
- Bach, P., Gaudiano, B. A., Hayes, S. C., & Herbert, J. D. (2013) Acceptance and commitment therapy for psychosis: intent to treat, hospitalization outcome and mediation by believability. *Psychosis*, 5(2), 166-174.
- Bach, P., Hayes, S.C. & Gallop (2012) Long-Term Effects of Brief Acceptance and Commitment Therapy for Psychosis. *Behavior Modification*, 36(2): 165-181.
- Baer, R. (ed) (2006) *Mindfulness-Based Treatment Approaches. Clinician's Guide to Evidence Base and Applications*. London: Elsevier.
- Baer, R. A. (2003) Mindfulness Training as a Clinical Intervention: A Conceptual and Empirical Review. *Clinical Psychology: Science and Practice*, 10(2): 125-143.
- Baer, R. A., Smith, G. T., Lykins, E., Button, D., Krietemeyer, J., Sauer, S. & Williams, J. M. G. (2008) Construct validity of the five facet mindfulness questionnaire in meditating and nonmeditating samples. *Assessment*, 15(3), 329-342.
- Barbalet, J. (2002) Introduction: why emotions are crucial. *The Sociological Review*, 50(S2): 1-9.
- Barcan, R. (2011) *Complementary and alternative medicine: bodies, therapies, senses*. Oxford: Berg.
- Bargiela-Chiappini, F. (2011) Discourse (s), social construction and language practices: In conversation with Alvesson and Kärreman. *Human Relations*, 64(9), 1177-1191.
- Barker, K. (2014) Mindfulness meditation: Do-it-yourself medicalization of every moment. *Social Science & Medicine*, 106, 168-176.
- Barnes, B. (2013) *Scientific knowledge and sociological theory* (Vol. 2). London: Routledge.
- Barrett, L. F., & Lindquist, K. A. (2008) The embodiment of emotion. in Semin, G. &

- Smith, E. *Embodied grounding: Social, cognitive, affective, and neuroscience approaches* (237-262). New York: Cambridge University Press.
- Basso F., Oullier O. (2010) Embodied economics: how bodily information shapes the social coordination dynamics of decision-making. *Philosophical Transactions of the Royal Society. B* 365, 291–301.
- Bates, J. (2013) Take the blame: Jane Bates resents master manipulators. *Nursing Standard* 27.40: 24-25.
- Bawa, F. L. M., Mercer, S. W., Atherton, R. J., Clague, F., Keen, A., Scott, N. W., & Bond, C. M. (2015) Does mindfulness improve outcomes in patients with chronic pain? Systematic review and meta-analysis. *British Journal of General Practice*, 65(635), e387-e400.
- Bazeley, P., & Jackson, K. (eds.) (2013) *Qualitative data analysis with NVivo*. London: SAGE.
- Beach MC, Roter D, Korthuis PT et al. (2013) A multicenter study of physician mindfulness and health care quality. *The Annals of Family Medicine*, 11(5): 421-428.
- Beauchamp, T. (2007) in Ashcroft, R., Dawson, A. Heather Draper, H., and McMillan, J. (ed) *Principles of Health Care Ethics*. Chichester: John Wiley & Sons
- Bell, S. E., & Figert, A. E. (2012) Medicalization and pharmaceuticalization at the intersections: Looking backward, sideways and forward. *Social Science & Medicine*, 75(5), 775-783.
- Bellack, A. S. (2006) Scientific and consumer models of recovery in schizophrenia: concordance, contrasts, and implications. *Schizophrenia bulletin*, 32(3), 432-442.
- Bendelow, G. (1993) Pain perceptions, emotions and gender. *Sociology of Health & Illness*, 15(3), 273-294.
- Bendelow, G. (2009) *Health, emotion and the body*. London: Polity.
- Bendelow, G. (2010) Emotional health: challenging biomedicine or increasing health surveillance? *Critical Public Health*, 20 (4). pp. 465-474
- Bendelow, G. A., & Williams, S. J. (2014) Emotions and the Body: Raising the Issues for Medical Sociology. *Medical Sociology online*. 8:2. 45
- Bentall, R. (2006) Madness explained: Why we must reject the Kraepelinian paradigm and replace it with a 'complaint-orientated' approach to understanding mental illness. *Medical Hypotheses*. 66, 220–233
- Beresford, P., Nettle., M. & Perring, R. (2010) *Towards a social model of madness and distress? Exploring what service users say*. Joseph Rowntree Foundation. Available at: <http://www.jrf.org.uk/sites/files/jrf/mental-health-service-models-full.pdf> (Accessed: 3.5.15)

- Berg, M. & Timmermans, S. (2003) *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care*. Philadelphia: Temple University Press.
- Bernard, R. (2007) The social sharing of emotion as an interface between individual and collective processes in the construction of emotional climates. *Journal of social issues* 63.2: 307-322.
- Berry, C., & Hayward, M. (2011) What can qualitative research tell us about service user perspectives of CBT for psychosis? A synthesis of current evidence. *Behavioural and cognitive psychotherapy*, 39(04), 487-494.
- Bhattacharjee, A., & Neset, H. (2007) Physicians' resistance toward healthcare information technology: a theoretical model and empirical test. *European Journal of Information Systems* 16.6: 725-737.
- Birchwood, M., Connor, C., Lester, H., Patterson, P., Freemantle, N., Marshall, M. & Singh, S. P. (2013) Reducing duration of untreated psychosis: care pathways to early intervention in psychosis services. *The British Journal of Psychiatry*, 203(1), 58-64.
- Birke, L. (2000) *Feminism and the biological body*. New Brunswick, New Jersey: Rutgers University Press.
- Birken, S. A., Lee, S. Y., & Weiner, B. J. (2012) Uncovering middle managers' role in healthcare innovation implementation. *Implementation Science*, 7(1), 28.
- Bishop, F. L., Barlow, F., Coghlan, B., Lee, P., & Lewith, G. T. (2011) Patients as healthcare consumers in the public and private sectors: a qualitative study of acupuncture in the UK. *BMC health services research*, 11(1), 129.
- Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J. & Devins, G. (2004) Mindfulness: A proposed operational definition. *Clinical psychology: Science and practice*, 11(3), 230-241.
- Black, D. S. (2010) Mindfulness research guide: A new paradigm for managing empirical health information. *Mindfulness*, 1(3), 174-176.
- Bloor, M., Fincham, B., & Sampson, H. (2008) *Qualiti (NCRM) commissioned inquiry into the risk to well-being of researchers in Qualitative Research*. Available at: <http://www.cardiff.ac.uk/socsi/qualiti/CIReport.pdf> (Accessed: 21.10.14)
- Bluff, R. (2005) Grounded theory: the methodology. *Qualitative research in health care*, 147-167 in Holloway, I. (ed.) *Health Care*, Maidenhead: Open University Press.
- Bok, D. C. (2010) *The politics of happiness what government can learn from the new research on well-being*. Princeton: Princeton University Press.

- Bolton, S. C. (2000) Emotion here, emotion there, emotional organisations everywhere. *Critical Perspectives on Accounting*, 11(2), 155-171.
- Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., & Zettle, R. D. (2011) Preliminary psychometric properties of the Acceptance and Action Questionnaire-II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy*, 42(4), 676-688.
- Boon, H., & Kachan, N. (2008) Integrative medicine: a tale of two clinics. *BMC Complementary and Alternative Medicine* 8.1: 32.
- Boorman, S. (2009) *NHS health and well-being review: interim report*. Department of Health.
- Borbasi, S., Galvin, K. T., Adams, T., Todres, L., & Farrelly, B. (2013) Demonstration of the usefulness of a theoretical framework for humanising care with reference to a residential aged care service in Australia. *Journal of clinical nursing*, 22(5-6), 881-889.
- Borup, M., Brown, N., Konrad, K., & Van Lente, H. (2006) The sociology of expectations in science and technology. *Technology analysis & strategic management*, 18(3-4), 285-298.
- Bourdieu, P. (1984) *Distinction: A Social Critique of the Judgement of Taste*. Harvard: Harvard University Press.
- Bowker, G. C., & Star, S. L. (2000) *Sorting things out: Classification and its consequences*. Massachusetts: MIT press.
- Boyatzis, R. E. (1998) *Transforming qualitative information: Thematic analysis and code development*. London: SAGE.
- Boyle, M. (1990) *Schizophrenia, A Scientific delusion?* London: Routledge.
- Bracken P & Thomas P. (2001) Postpsychiatry: a new direction for mental health. *British Medical Journal*; 322: 724–7.
- Bracken, P. (2012) *Postpsychiatry - Reaching beyond the technological paradigm in mental health*. Lecture at the Forum for existential psychology & therapy, at University of Copenhagen, 18.4.12. Available at: <http://www.youtube.com/watch?v=cV5RKT6Q8qU> (Accessed: 11.3.13)
- Bracken, P., & Thomas, P. (2005) *Postpsychiatry: mental health in a postmodern world*. Oxford University Press.
- Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C. & Yeomans, D. (2012) Psychiatry beyond the current paradigm. *The British Journal of Psychiatry*, 201(6), 430-434.
- Braidotti, R (2013) *Metamorphoses: Towards a materialist theory of becoming*. Sussex: John Wiley & Sons.

- Braun, V. and Clarke, V. (2006) Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3: 77-101
- Breathworks (2014) Available at: <http://www.breathworks-mindfulness.org.uk> (Accessed: 17.6.14)
- Brewer, J. A., Worhunsky, P. D., Gray, J. R., Tang, Y. Y., Weber, J., & Kober, H. (2011) Meditation experience is associated with differences in default mode network activity and connectivity. *Proceedings of the National Academy of Sciences*, 108(50).
- Brousselle, A., & Lessard, C. (2011) Economic evaluation to inform health care decision-making: promise, pitfalls and a proposal for an alternative path. *Social science & medicine*, 72(6), 832-839.
- Brown, K. W., Ryan, R. M., & Creswell, J. D. (2007) Addressing fundamental questions about mindfulness. *Psychological Inquiry*, 18(4), 272-281
- Brown, M. M., & Brown, G. C. (2013) Update on value-based medicine. *Current opinion in ophthalmology*, 24(3), 183-189.
- Brown, N. (2003) Hope against hype: accountability in biopasts, presents and futures. *Science studies*, 16(2), 3-21.
- Brown, N. (2006) Shifting tenses - from regimes of truth to regimes of hope. Paper presented at *Shifting Politics-politics of technology-the times they are a-changin'*, Groningen, April, 21-22. Available at: <https://www.york.ac.uk/media/satsu/documents-papers/Brown-2006-shifting.pdf> (Accessed 13.10.16)
- Brown, N., & Michael, M. (2003) A sociology of expectations: retrospectively prospecting and prospecting retrospects. *Technology Analysis & Strategic Management*, 15(1), 3-18.
- Bryman, A. (2012) *Social Research Methods*. 4th ed. Oxford University Press
- Bryman, A., & Cramer, D. (2005) *Quantitative data analysis with SPSS 12 and 13: a guide for social scientists*. East Sussex: Psychology Press.
- Burkitt, I. (1997) Social Relationships and Emotions. *Sociology*. Vol. 31 no. 1 37-55
- Burkitt, I. (2014) *Emotions and social relations*. London: SAGE.
- Burnham, J. C. (2000) Jack Pressman and the Future of the History of Psychiatry. *Bulletin of the History of Medicine*, 74(4), 778-785.
- Burr, V. (1998) Overview: Realism, relativism, social constructionism and discourse in Parker, I. (ed.), *Social constructionism, discourse and realism* (pp. 13-26). London: SAGE.
- Burton, N. (2008) *The meaning of madness*. Oxon: Acheron Press.

- Busfield, J. (2000) Introduction: Rethinking the sociology of mental health. *Sociology of health & illness*, 22(5), 543-558.
- Byron, G., Ziedonis, D. M., McGrath, C., Frazier, J. A., & Fulwiler, C. (2014) Implementation of Mindfulness Training for Mental Health Staff: Organizational Context and Stakeholder Perspectives. *Mindfulness*, 1-12.
- Cant, S., & Sharma, U. (1999) *A new medical pluralism*. London: Garland.
- Cant, S., & Sharma, U. (2004) *A New Medical Pluralism: complementary medicine, doctors, patients and the state*. London: Routledge.
- Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014) The use of triangulation in qualitative research. In *Oncology nursing forum*, 41,(5), 545-547).
- Carter, S. & Little, M. (2007) Justifying Knowledge, Justifying Method, Taking Action: Epistemologies, Methodologies and Methods in Qualitative Research. *Qualitative Health Research*. 17: 1316.
- Cartwright, N. (2011) A philosopher's view of the long road from RCTs to effectiveness. *The Lancet*, 377(9775), 1400-1401.
- Cassidy, L. (2012) Mindful Breathing: Creating Counterpublic Space in the Religious Studies Classroom. *Journal of Feminist Studies in Religion*, 28(1), 164-177.
- Cavanagh, K., Strauss, C., Forder, L., & Jones, F. (2014) Can mindfulness and acceptance be learnt by self-help? A systematic review and meta-analysis of mindfulness and acceptance-based self-help interventions. *Clinical psychology review*, 34(2), 118-129.
- Cayoun, B. A. (2011) *Mindfulness-integrated CBT: Principles and practice*. Sussex: John Wiley & Sons.
- Centre for Mindfulness Research and Practice (CMRP) *National conference* (2013). Available at: <http://www.cmrpconference.com> (Accessed: 29.8.15)
- Chadwick, P. (2000) Spiritual experience or religious psychosis? *Nursing Times*. 96(16): 42-43.
- Chadwick, P. (2002) Spirituality and psychosis from the inside. *Journal of Critical Psychology, Counselling and Psychotherapy* 2(4): 203-207.
- Chadwick, P. (2008) *Self-Acceptance and the Symbolic Self. Person-Based Cognitive Therapy for Distressing Psychosis*. Sussex: John Wiley & Sons
- Chadwick, P. D., Birchwood, M. J., & Trower, P. (1996) *Cognitive therapy for delusions, voices and paranoia*. Sussex: John Wiley & Sons.
- Chadwick, P., Hember, M., Symes, J., & Dagnan, D. (2008) Responding mindfully to unpleasant thoughts and images: Reliability and validity of the Southampton

- mindfulness questionnaire (SMQ). *British Journal of Clinical Psychology* 47(4): 451-455.
- Chamberlain, K., Stephens, C., & Lyons, A. C. (1997) Encompassing experience: meanings and methods in health psychology. *Psychology and Health*, 12(5), 691-709.
- Chambers, R., Gullone, E., & Allen, N. B. (2009) Mindful emotion regulation: An integrative review. *Clinical psychology review*, 29(6), 560-572.
- Chandler, A. (2012) Self-injury as Embodied Emotion Work: Managing Rationality, Emotions and Bodies. *Sociology*, 46, 3442-457
- Chaskalson, M. (2011) *The mindful workplace: developing resilient individuals and resonant organizations with MBSR*. Sussex: John Wiley & Sons.
- Chiesa, A. (2013) The difficulty of defining mindfulness: current thought and critical issues. *Mindfulness*, 4(3), 255-268.
- Chiesa, A., & Malinowski, P. (2011) Mindfulness-based approaches: are they all the same?. *Journal of clinical psychology*, 67(4), 404-424.
- Chiesa, A., & Serretti, A. (2011) Mindfulness based cognitive therapy for psychiatric disorders: a systematic review and meta-analysis. *Psychiatry research*, 187(3), 441-453.
- Churchill, E. F. (2012) More than a feeling. *Interactions*, 19(1), 10-13.
- Clark, D. M. (2011) Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of Psychiatry*, 23(4), 318-327.
- Clarke, A. E., & Shim, J. (2011) Medicalization and biomedicalization revisited: technoscience and transformations of health, illness and American medicine. In *Handbook of the sociology of health, illness, and healing* (pp. 173-199). New York: Springer.
- Cleeremans, A., & Jiménez, L. (2002) Implicit learning and consciousness: A graded, dynamic perspective. *Implicit learning and consciousness*, 1-40. Hove: Psychology Press.
- Coffey, K. A., Hartman, M., & Fredrickson, B. L. (2010) Deconstructing mindfulness and constructing mental health: Understanding mindfulness and its mechanisms of action. *Mindfulness*, 1(4), 235-253.
- Coliva, A. (2012) *The self and self-knowledge*. Oxford: Oxford University Press.
- Collins, R. (1990) Stratification, emotional energy, and the transient emotions. *Research agendas in the sociology of emotions*, 27-57.
- Collins, R. (2004) Rituals of solidarity and security in the wake of terrorist attack. *Sociological Theory*, 22(1), 53-87.

- Colquhoun, D. (2007) Head to Head: Should NICE evaluate complementary and alternative medicines? *British Medical Journal*, 334(7592), 507.
- Compton, W.M., & Guze, S.B. (1995) The neo-Kraepelinian revolution in psychiatric diagnosis. *European Archives of Psychiatry and Clinical Neuroscience*. 245, (4).196-201.
- Conrad, P. (1979) Types of medical social control. *Sociology of Health and Illness*, 1(1), 1-11.
- Cooper, C., O'Cathain, A., Hind, D., Adamson, J., Lawton, J., & Baird, W. (2014) Conducting qualitative research within Clinical Trials Units: Avoiding potential pitfalls. *Contemporary clinical trials*, 38(2), 338-343.
- Corbin, J. & Strauss, A. (1998) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. London: SAGE.
- Craib, I. (1994) *The Importance of Disappointment*. London: Routledge.
- Crane, R. S. and W. Kuyken (2013) The Implementation of Mindfulness-Based Cockerham, W. (ed.) *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society*. London: Wiley-Blackwall
- Cognitive Therapy: Learning From the UK Health Service Experience. *Mindfulness* 4(3): 246-254.
- Crawford, R. (1980) Healthism and the medicalization of everyday life. *International journal of health services*, 10(3), 365-388.
- Crawford, R. (2004) Risk ritual and the management of control and anxiety in medical culture. *Health*, 8(4), 505-528.
- Critical Appraisal Skills Program (CASP). Available at: <http://www.casp-uk.net/#!casp-tools-checklists/c18f8> (Accessed 18.3.16).
- Cromheeke, S., & Mueller, S. C. (2014) Probing emotional influences on cognitive control: an ALE meta-analysis of cognition emotion interactions. *Brain Structure and Function*, 219(3), 995-1008.
- Crossley, N. (1995) Merleau-Ponty, the Elusive Body and Carnal Sociology. *Body & Society*. 1: 43-63
- Crossley, N. (2013) Habit and habitus. *Body & Society*, 19(2-3), 136-161.
- Csordas, T. (ed) (1994) *Embodiment and Experience, The existential ground of culture and self*. Cambridge: Cambridge University Press.
- Cullen, M. (2011) Mindfulness-based interventions: An emerging phenomenon. *Mindfulness*, 2(3), 186-193.
- Culyer, A. J., & Bombard, Y. (2012) An equity framework for health technology assessments. *Medical Decision Making*, 32(3), 428-441.

- Cummins, S., Curtis, S., Diez-Roux, A. V., & Macintyre, S. (2007) Understanding and representing 'place' in health research: a relational approach. *Social science & medicine*, 65(9), 1825-1838.
- Curtis, R. (2012) New Experience and Meanings- A Model Change for Psychoanalysis. *Psychoanalytic Psychology*. 29.(1), 81-98.
- Dacher, E. (2014) A Brief History of Mind-Body Medicine. *International Journal of Transpersonal Studies*, 33(1), 148-157.
- Dale, P., & Letchfield, P. (2000). Promoting independence in Brighton and Hove. *Journal of Integrated Care*, 8(2), 23-33.
- Damasio, A. (1999) *The Feeling of What Happens*. London: Random House.
- Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009) Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science*, 4(1), 50.
- Davidson, L. (2005) Recovery, self-management and the expert patient—changing the culture of mental health from a UK perspective. *Journal of Mental Health*, 14(1), 25-35.
- Davidson, R. (2010) Empirical explorations of mindfulness: Conceptual and methodological conundrums. *Emotion*, 10(1), 8-11.
- Davis, DA,. Thomson, MA,. Oxman, AD,. & Haynes, RB. (1995) Changing physician performance: a systematic review of the effect of educational strategies. *Journal of the American Medical Association*. 274:700–705.
- Davis, J. B. (2013) *The theory of the individual in economics: Identity and value*. London: Routledge.
- Dawson, M. (2013) *Late modernity, individualization and socialism: an associational critique of neoliberalism*. London: Palgrave Macmillan.
- Dawson, S., & Morris, Z. S. (2008) *Future Public Health: Burden, Challenges and Opportunities*. London: Palgrave Macmillan.
- De Leersnyder, J., Mesquita, B., Kim, H., Eom, K., & Choi, H. (2014) Emotional fit with culture: A predictor of individual differences in relational well being. *Emotion*, 14(2), 241.
- De Rivera, J. (1992) Emotional climate: Social structure and emotional dynamics. *International Review of Studies on Emotion* 2: 197-218.
- De Rivera, J., & Páez, D. (2007) Emotional climate, human security, and cultures of peace. *Journal of social issues*, 63(2), 233-253.
- De Saussure, F., & Baskin, W. (2011) *Course in general linguistics*. Columbia: Columbia University Press.

- De Silva, D. (2011) *Evidence: Helping people help themselves*. Report for The Health Foundation. Available at: <http://www.health.org.uk/publication/evidence-helping-people-help-themselves>. (Accessed: 3.8.15).
- Deegan, P. (1996) Recovery as a journey of the heart. *Psychosoc Rehabilitation Journal*, 19:91–97
- Dent, T. H., & Sadler, M. (2002) From guidance to practice: why NICE is not enough. *British Medical Journal*, 324(7341), 842.
- Denzin, N (2009) *On Understanding Emotion*. New Jersey: Transaction Publishers.
- Denzin, N. (2012) Triangulation 2.0. *Journal of Mixed Methods Research*, 6(2) 80-88.
- Department of Health (2001) *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century*. Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4006801. (Accessed: 4.5.15).
- Department of Health (2011) *No Health Without Mental Health*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf (Accessed: 29.8.15).
- Derkatch, C. (2008) Method as argument: Boundary work in evidence-based medicine. *Social Epistemology*, 22(4), 371-388.
- Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2009) Researching sensitive topics: qualitative research as emotion work. *Qualitative Research*, 9(1), 61-79.
- Dixon-Woods, M., Jackson, C., Windridge, K. C., & Kenyon, S. (2006) Receiving a summary of the results of a trial: qualitative study of participants' views. *British Medical Journal*, 332(7535), 206-210.
- Doel, M.A. and Segrott, J., (2003) Beyond belief? Consumer culture, complementary medicine, and the dis-ease of everyday life. *Environment and Planning D: Society and Space*, 21(6), pp.739-759.
- Doganova, L., Giraudeau, M., Helgesson, C. F., Kjellberg, H., Lee, F., Mallard, A. & Zuiderent-Jerak, T. (2014) Valuation Studies and the Critique of Valuation. *Valuation Studies*, 2(2), 87-96.
- Dolan, P., Peasgood, T., & White, M. (2008) Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being. *Journal of economic psychology*, 29(1), 94-122.
- Donahue, J. J., Goranson, A. C., McClure, K. S., & Van Male, L. M. (2014) Emotion dysregulation, negative affect, and aggression: A moderated, multiple mediator

analysis. *Personality and Individual Differences*, 70, 23-28.

Donavan, J., Mills, N., Smith, M., Brindle, L., Jacoby, A., & Peters, T. (2002) Improving design and conduct of randomised trials by embedding them in qualitative research: ProtecT (prostate testing for cancer and treatment) study. *British Medical Journal*, 325, 766-770.

Dopson, S., Fitzgerald, L., & Ferlie, E. (2008) Understanding change and innovation in healthcare settings: reconceptualizing the active role of context. *Journal of change management*, 8,(4) 213-231.

Double, D. (2002) The limits of psychiatry. *British Medical Journal*; 324,900-904.

Drake, R. E., Goldman, H. H., Leff, H. S., Lehman, A. F., Dixon, L., Mueser, K. T., & Torrey, W. C. (2014) Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services* 52, (2) 179-182.

Drummond, M. F. (2005) *Methods for the economic evaluation of health care programmes*. Oxford: Oxford University Press.

Durkheim, E. (1976) *The elementary forms of the religious life*. London: Routledge.

Dyer, C (2008) Myeloma patient wins fight for drug not yet approved by NICE. *British Medical Journal*; 337:a1695.

East Sussex Health and Wellbeing Board (2014). Available at:

<http://www.eastsussex.gov.uk/yourcouncil/about/committees/meetings/healthwellbeing.htm> (Accessed: 13.10.14).

Edenfield, T. M., & Saeed, S. A. (2012) An update on mindfulness meditation as a self-help treatment for anxiety and depression. *Psychology research and behavior management*, 5, 131.

Edwards, R. T., Bryning, L., & Crane, R. (2014) Design of Economic Evaluations of Mindfulness-Based Interventions: Ten Methodological Questions of Which to Be Mindful. *Mindfulness*, 6(3), 490-500.

Elliot, A. (2007) *Concepts of the Self*. Cambridge: Polity.

Emavardhana, T., & Tori, C. D. (1997) Changes in self-concept, ego defense mechanisms, and religiosity following seven-day Vipassana meditation retreats. *Journal for the scientific study of religion*, 194-206.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2001) Participant observation and fieldnotes. *Handbook of ethnography*, 352-368.

Epstein, M. (1984) On the Neglect of Evenly Suspended Attention. *The Journal of Transpersonal Psychology*, 16(2).

Epstein, M. (2008) *Psychotherapy Without the Self: A Buddhist Perspective*. USA: Yale University Press.

- Ernst, E. (2000) Prevalence of use of complementary/alternative medicine: a systematic review. *Bulletin of the World Health Organization*, 78(2), 258-266.
- Ernst, E., & White, A. (2000) The BBC survey of complementary medicine use in the UK. *Complementary therapies in medicine*, 8(1), 32-36.
- Eskinazi, D. (1999) Homeopathy re-revisited: is homeopathy compatible with biomedical observations?. *Archives of internal medicine*, 159(17), 1981-1987.
- Evans, D. (2003) Hierarchy of evidence: a framework for ranking evidence evaluating healthcare interventions. *Journal of Clinical Nursing*, 12(1), 77-84.
- Fairclough, N. (2013) *Critical Discourse Analysis: The critical study of language*. London: Routledge.
- Fairhurst, K. & Huby, G. (1998) From trial data to practical knowledge: qualitative study of how general practitioners have accessed and used evidence about statin drugs in their management of hypercholesterolaemia. *BMJ*, 317(7166), pp.1130-1134.
- Farb, N. A., Anderson, A. K., Mayberg, H., Bean, J., McKeon, D., & Segal, Z. V. (2010) Minding one's emotions: mindfulness training alters the neural expression of sadness. *Emotion*, 10(1), 25.
- Faulkner, A., & Thomas, P. (2002) User-led research and evidence-based medicine. *The British Journal of Psychiatry*, 180(1), 1-3.
- Fausto-Sterling, A. (2000) *Sexing the body: Gender politics and the construction of sexuality*. New York: Basic Books.
- Featherstone, M. & Turner, B. (1995) Body and society: An introduction. *Body & Society* 1: 1-12.
- Field, A. (2013) *Discovering statistics using IBM SPSS statistics*. London: SAGE.
- Fielding, N., & Fielding, J. L. (1986) *Linking data* (Vol. 4). Beverly Hills, CA: SAGE.
- Fitzgerald, L., Ferlie, E., & Hawkins, C. (2003) Innovation in healthcare: how does credible evidence influence professionals?. *Health & social care in the community*, 11(3), 219-228.
- Fitzgerald, L., Ferlie, E., Wood, M., & Hawkins, C. (2002) Interlocking interactions, the diffusion of innovations in health care. *Human relations*, 55(12), 1429-1449.
- Flam, H., & Kleres, J. (ed). (2015) *Methods of Exploring Emotions*. London: Routledge.
- Floyd, M., Scogin, F., & Chaplin, W. F. (2004) The Dysfunctional Attitudes Scale: factor structure, reliability, and validity with older adults. *Aging & mental health*, 8(2), 153-160.
- Flynn, M., & Mercer, D. (2012) Is compassion possible in a market-led NHS?. *Nursing times*, 109(7), 12-14.

- Fortney L, Luchterhand C, Zakletskaia L, Zgierska, A., & Rakel, D. (2013) Abbreviated mindfulness intervention for job satisfaction, quality of life, and compassion in primary care clinicians: a pilot study. *Annals of Family Medicine*, 11(5):412-420.
- Foucault, M. (1973) *The Birth of the Clinic*, trans. A. Sheridan, London: Tavistock.
- Foucault, M. (1988) *Madness and civilization: A history of insanity in the age of reason*. London: Vintage.
- Fox, N. (1998) Foucault, Foucauldians and Sociology. *The British Journal of Sociology*. 49,(3).
- Fox, N. J., & Ward, K. J. (2008) What are health identities and how may we study them?. *Sociology of health & illness*, 30(7), 1007-1021.
- Franck, L., Chantler, C., & Dixon, M. (2007) Head to Head: Should NICE evaluate complementary and alternative medicine? *British Medical Journal*, 334(7592), 506.
- Frank, A. (1990) Bringing Bodies Back in: A Decade Review. *Theory Culture Society*, 7: 131.
- Frantic World (2014) *Three Minute Breathing Space*. Available at: <http://franticworld.com/the-three-minute-breathing-space-meditation-is-now-free-to-download>. (Accessed: 19.6.14).
- Free Mindfulness (2014) Available at: <http://www.freemindfulness.org/download>. (Accessed: 19.6.14).
- Freeman, A.C. and Sweeney, K. (2001) Why general practitioners do not implement evidence: qualitative study, *British Medical Journal*, 323, 1100–5.
- Freund, P. (2008) The expressive body: a common ground for the sociology of emotions and health and illness. *Sociology of Health & Illness*, 12,(4), 452–477.
- Frey, B. & Stutzer, A. (2010) *Happiness and Economics: How the Economy and Institutions Affect Human Well-Being*. New Jersey: Princeton University Press.
- Tan, C. M (2014) Front cover of 'Search Inside Yourself' (2014) London: Collins [image] Available at: https://www.google.com/search?site=&tbm=isch&source=hp&biw=1366&bih=622&q=mindfulness+publications&oq=mindfulness+publications&gs_l=img.3..0j0i24.409.2476.0.3118.15.4.1.10.11.0.68.257.4.4.0....0...1ac.1.64.img..0.14.302.VDLvU0zzlkc#tbm=isch&q=google+mindfulness+publication&imgsrc=Hmc6xTTmnzKOdM%3A (Accessed: 10.8.14).
- Fulford, K. (2008) Values-Based Practice: A New Partner to Evidence-Based Practice and a First for Psychiatry? *Mens Sana Monographs*. 6(1): 10-21.

- Fulford, K. (2011) Bringing together values-based and EBM: UK Department of Health Initiatives in the 'Personalization' of Care. *Journal of evaluation in clinical practice*, 17(2), 341-343.
- Furedi, F. (2003) *Therapy culture: Cultivating vulnerability in an uncertain age*. London: Routledge.
- Gabe, J. & Monaghan, L. (ed.) (2013) Second ed. *Key Concepts in Medical Sociology*. London: SAGE.
- Gabe, J., Bury, M. & Elston, M. (2004) *Key Concepts in Medical Sociology*. London: SAGE.
- Gale, N. (2014) The Sociology of Traditional, Complementary and Alternative Medicine, *Sociology Compass*, 8: 805–822.
- Gale, N. K. & McHale, J. V. (ed.) (2015) *Routledge Handbook of Complementary and Alternative Medicine. Perspectives from Social Science and Law*. London: Routledge.
- Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013) Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology*, 13(1), 117.
- Gale, N. K. & McHale, J. V. (ed.) (2015) *Routledge Handbook of Complementary and Alternative Medicine. Perspectives from Social Science and Law*. London: Routledge
- Gendron, M. & Barrett, L.F. (2009) Reconstructing the Past: A Century of Ideas about Emotion in Psychology. *Emotion Review*. 1; 1(4): 316–339.
- Gendron, M. (2010) Defining Emotion: A Brief History, *Emotion Review* 2: 371.
- Gergen, K. (2008) Therapeutic challenges of multi-being. *Journal of Family Therapy*. 30(4); 335-350.
- Germer, C. K., & Siegel, R. D. (ed.) (2012) *Wisdom and compassion in psychotherapy: Deepening mindfulness in clinical practice*. New York: Guilford Press.
- Germer, C. K., Siegel, R. D., & Fulton, P. R. (ed.) (2013) *Mindfulness and psychotherapy*. New York: Guilford Press.
- Geschwind, N., Peeters, F., Drukker, M., van Os, J., & Wichers, M. (2011) Mindfulness training increases momentary positive emotions and reward experience in adults vulnerable to depression: a randomized controlled trial. *Journal of consulting and clinical psychology*, 79(5), 618.
- Gifford, S. (1996) Qualitative research: the soft option?. *Health Promotion Journal of Australia*: 6, 1.
- Giorgi, A. (2009) *The descriptive phenomenological method in psychology: A*

- modified Husserlian approach*. Pittsburgh: Duquesne University Press.
- Givati, A. (2012) *The holistic discourse and formalising education of non-medically qualified acupuncturists and homeopaths in England: An in depth, qualitative study* (Doctoral dissertation, University of Portsmouth). Available at: <http://eprints.port.ac.uk/10597> (Accessed on: 13.3.15).
- Goertz, G., & Mahoney, J. (2012) *A tale of two cultures: Qualitative and quantitative research in the social sciences*. New Jersey: Princeton University Press.
- Goffman, E. (2012) The presentation of self in everyday life [1959]. *Contemporary sociological theory*, 46-61.
- Gold, J. (1985) Cartesian dualism and the current crisis in medicine--a plea for a philosophical approach: discussion paper. *Journal of the Royal Society of Medicine*, 78(8), 663
- Goldacre, B. (2006) *Bad Science*. London: Fourth Estate
- Goldacre, B. (2012) *Big Pharma: How Drug Companies Mislead Doctors and Harm Patients*. London: Faber & Faber
- Goldin, P. R., & Gross, J. J. (2010) Effects of mindfulness-based stress reduction (MBSR) on emotion regulation in social anxiety disorder. *Emotion*, 10(1), 83.
- Goleman, D. (ed.) (2003) *Healing emotions*. Boston: Shambhala Publications
- Good, M. J. D. (2010) The medical imaginary and the biotechnical embrace. A *Reader in Medical Anthropology: Theoretical Trajectories, Emergent Realities*, 272.
- Goyal, M., Singh, S., Sibinga, E. M., Gould, N. F., Rowland-Seymour, A., Sharma, R. & Haythornthwaite, J. A. (2014) Meditation programmes for psychological stress and well-being: a systematic review and meta-analysis. *Journal of the American Medical Association*, 174(3), 357-368
- Grabovac, A. D., Lau, M. A., & Willett, B. R. (2011) Mechanisms of mindfulness: A Buddhist psychological model. *Mindfulness*, 2(3), 154-166.
- Grbich, C. (2003) *Qualitative Research in Health: An Introduction*. London: SAGE
- Green, J., & Britten, N. (1998) Qualitative research and evidence based medicine. *British Medical Journal*. 316 (7139): 1230–1232.
- Green, J., Willis, K., Hughes, E., Small, R., Welch, N., Gibbs, L., Daly, J. (2007) Generating best evidence from qualitative research: the role of data analysis. *Australian and New Zealand Journal of Public Health*. 31,(6) 545–550
- Greenhalgh, T. (2009) Chronic illness: beyond the expert patient. *British Medical Journal*, 629-631.
- Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004) Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Quarterly*, 82(4), 581-629.

- Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., Kyriakidou, O., & Peacock, R. (2005) Storylines of research in diffusion of innovation: a meta-narrative approach to systematic review. *Social science & medicine*, 61(2), 417-430
- Greenwood, K. E., Sweeney, A., Williams, S., Garety, P., Kuipers, E., Scott, J., & Peters, E. (2009) Choice of outcome in CBT for psychoses (CHOICE): the development of a new service user-led outcome measure of CBT for psychosis. *Schizophrenia bulletin*, sbp117.
- Greeson, J. M. (2009) Mindfulness research update: 2008. *Complementary health practice review*. 1; 14(1): 10–18
- Griffiths, F., et al. (2006) Health professionals, their medical interventions and uncertainty: A study focusing on women at midlife. *Social Science and Medicine* 62(5): 1078-1090.
- Grimshaw, J. M., Thomas, R .E., MacLennan, G., Fraser, C., Ramsay, C.R., Vale, L., Whitty, P., Eccles, M.P., Matowe, L., Shirran, L., Wensing, M., Dijkstra, R., & Donaldson, C. (2004) Effectiveness and efficiency of guideline dissemination and implementation strategies. *Health Technology Assessment*, 8(6): iii-iv, 1-72.
- Grol R, & Wensing M (2004) What drives change? Barriers to and incentives for achieving evidence-based practice. *The Medical Journal of Australia*. 180(6 Suppl):57-60
- Grossman, P. (2010) Mindfulness for psychologists: Paying kind attention to the perceptible. *Mindfulness*, 1(2), 87-97.
- Grossman, P., & Van Dam, N. T. (2011) Mindfulness, by any other name: trials and tribulations of sati in western psychology and science. *Contemporary Buddhism*, 12(01), 219-239.
- Guarneri, E. M., Horrigan, B. J., & Pechura, C. M. (2010) The efficacy and cost-effectiveness of integrative medicine: a review of the medical and corporate literature. *Explore: The Journal of Science and Healing*, 6(5), 308-312.
- Gupta, M. (2011a) Improved health or improved decision making? The ethical goals of EBM. *Journal of evaluation in clinical practice*, 17(5), 957-963
- Gupta, M., (2011b) Values-based practice and bioethics: close friends rather than distant relatives. Commentary on Fulford (2011). The value of evidence and evidence of values: bringing together values-based and evidence-based practice in policy and service development in mental health'. *Journal of evaluation in clinical practice*, 17(5), pp.992-995
- Gusterson, H. (2007) Anthropology and militarism. *Annual Review Anthropology*. 36, 155-175.

- Gyani, A., Shafran, R., Myles, P., & Rose, S. (2014) The gap between science and practice: How therapists make their clinical decisions. *Behavior therapy*, 45(2), 199-211.
- Hall, C., Davies, J. K., & Sherriff, N. (2010) Health in the urban environment: a qualitative review of the Brighton and Hove WHO Healthy City Programme. *Journal of Urban Health*, 87(1), 8-28.
- Halliwell, E. (2010) Mental Health Foundation Report *Living Mindfully*. Available at: http://www.livingmindfully.co.uk/downloads/Mindfulness_Report.pdf (Accessed: 20.8.15).
- Hamilton, N. A., Kitzman, H., & Guyotte, S. (2006) Enhancing health and emotion: Mindfulness as a missing link between cognitive therapy and positive psychology. *Journal of Cognitive Psychotherapy*, 20(2), 123-134.
- Hammersley, M., & Atkinson, P. (2007) *Ethnography: Principles in practice*. London: Routledge.
- Hanley, A. W., & Garland, E. L. (2014) Dispositional mindfulness co-varies with self-reported positive reappraisal. *Personality and individual differences*, 66, 146-152
- Hannerz, U. (2002) Among the foreign correspondents: reflections on anthropological styles and audiences. *Ethnos*, 67(1), 57-74.
- Hansen, E. (2006) *Successful qualitative health research: a practical introduction*. New South Wales: Allen and Unwin
- Harris, J. L., Schwartz, M. B., & Brownell, K. D. (2010) Marketing foods to children and adolescents: licensed characters and other promotions on packaged foods in the supermarket. *Public health nutrition*, 13(03), 409-417.
- Harrison, S., & Mort, M. (1998) Which champions, which people? Public and user involvement in health care as a technology of legitimation. *Social Policy & Administration*, 32(1), 60-70
- Hayes, A. M., & Feldman, G. (2004) Clarifying the construct of mindfulness in the context of emotion regulation and the process of change in therapy. *Clinical Psychology: science and practice*, 11(3), 255-262.
- Haynes, B. & Haines, A. (1998) *Barriers and bridges to evidence based clinical practice*. British Medical Journal. 317(7153): 273-276
- Head Space (2015) Available at: <https://www.headspace.com>. (Accessed: 24.3.15)
- Headspace Application screenshots (2015) [image] Available at: https://www.google.co.uk/search?site=imghp&tbm=isch&source=hp&biw=1242&bih=606&q=headspace+app&oq=headspace&gs_l=img.3.1.0l10.938.3335.0.5900.9.7.0.1.1.0.183.861.1j6.7.0....0...1ac.1.64.img..2.7.713.ow3IAL7cFEI#imgsrc=H9bkQx1ScVyWmM%3A (Accessed: 6.5.15)

- Health Improvement Analytical Team (2014) Healthcare Sector Staff Wellbeing, Service delivery and health outcomes, *Department of Health Factsheet*. Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277591/Staff_wellbeing__service_delivery_and_health_outcomes.pdf (Accessed: 1.4.15).
- Health Improvement Scotland (2015) Available at:
<http://www.sign.ac.uk/pdf/SIGN136.pdf>. (Accessed: 24.8.15)
- Health in Mind (2015) Available at: <http://www.healthinmind.org.uk>. (Accessed: 21.8.15)
- Heaversedge, J., & Halliwell, E. (2012) *The Mindful Manifesto*. London: Hay House, Inc.
- Helgesson, C. F., & Muniesa, F. (2013) For what it's worth: An introduction to valuation studies. *Valuation Studies*, 1(1), 1-10.
- Hendy, J., & Barlow, J. (2012) The role of the organizational champion in achieving health system change. *Social Science & Medicine*, 74(3), 348-355.
- Hick, S. (2010) Cultivating Therapeutic Relationships: The Role of Mindfulness. *Mindfulness and the therapeutic relationship*. 3-18
- Hochschild, A. (1979) Emotion Work, Feeling Rules, and Social Structure. *American Journal of Sociology*. 85, (3), 551-575
- Hochschild, A. (1983) *Managed Heart: The Commercialization of Human Feeling*. Berkeley: The University of California Press
- Hochschild, A. (2012) *The Outsourced Self: Intimate Life in Market Times*. New York: Metropolitan Books
- Hochschild, A. R. (1990) Ideology and emotion management: A perspective and path for future research. *Research agendas in the sociology of emotions*, 117, 142.
- Hofmann, S.G., Sawyer, A.T., Witt, A.A., & Oh, D. (2010) The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology*. 78(2):169–183
- Holloway, I. (ed.), *Qualitative research in health care* (pp. 3–16). New York: McGraw-Hill.
- Holmes, M. (2010) The emotionalization of reflexivity. *Sociology*, 44(1), 139-154.
- House of Lords Science and Technology Select Committee 2nd Report of Session 2010–12 (2011) *Behaviour Change*. Available at:
<http://www.publications.parliament.uk/pa/ld201012/ldselect/ldsctech/179/179.pdf> (Accessed: 14.3.13).

- Howells, A., Ivztan, I., & Eiroa-Orosa, F. J. (2014) Putting the 'app' in Happiness: A Randomised Controlled Trial of a Smartphone-Based Mindfulness Intervention to Enhance Wellbeing. *Journal of Happiness Studies*, 1-23.
- Howson, A. (2013) *The body in society: An introduction*. Sussex: John Wiley & Sons.
- Hughes, J. C., & Fulford, K. W. M. (2005) Hurly-burly of psychiatric ethics. *Australian and New Zealand journal of psychiatry*, 39(11-12), 1001-1007.
- Iedema, R. (2011) Discourse studies in the 21st century: A response to Mats Alvesson and Dan Kärreman's 'Decolonializing discourse'. *Human Relations*, 64(9): 1163-1176
- Ignatow, G. (2007) Theories of embodied knowledge: new directions for cultural and cognitive sociology? *Journal for the Theory of Social Behaviour*, 37(2), 115-135.
- Imison, C., Naylor, C. G. N., Buck, D., Curry, N., Addicott, R., & Zollinger-Read, P. (2015) *Transforming our healthcare system*. London: The King's Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf (Accessed on: 21.8.15)
- Increasing Access to Psychological Therapies (IAPT). Available at: <http://www.iapt.nhs.uk/about-iapt> (Accessed on: 28.1.13)
- Ingleby, D (ed) (1980) *Critical Psychiatry, The Politics of Mental Health*. Great Britain: Penguin Books
- Institute of Employment Studies (2014) *Workplace policy and management practices to improve the health and wellbeing of employees*. Available at: <http://www.employment-studies.co.uk/resource/workplace-policy-and-management-practices-improve-health-and-wellbeing-employees>. (Accessed on: 21.7.15)
- Isaac, M. L., & Paauw, D. S. (2014) Medically unexplained symptoms. *Medical Clinics of North America*, 98(3), 663-672.
- Jablensky, A. & Sartorius, N. (2008) What Did the WHO Studies Really Find? *Schizophrenia Bulletin* (2008) 34 (2): 253-255
- Jacobson, N., & Curtis, L. (2000) Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, 23(4), 333.
- Jarvis, A., Perry, R., Smith, D., Terry, R., & Peters, S. (2015) General practitioners' beliefs about the clinical utility of complementary and alternative medicine. *Primary health care research & development*, 16(03), 246-253
- Jewson, N. D. (1976) The disappearance of the sick-man from medical cosmology, 1770-1870. *Sociology*, 10(2), 225-244.

- Johanson, G. (2011) *A Survey of the Use of Mindfulness in Psychotherapy*. Available at: <http://www.gregjohanson.net/page.asp?ID=103>. (Accessed on: 17.10.12)
- Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007) Toward a definition of mixed methods research. *Journal of mixed methods research*, 1(2), 112-133.
- Jolley, S., Garety, P. A., Ellett, L., Kuipers, E., Freeman, D., Bebbington, P. E & Dunn, G. (2006) A validation of a new measure of activity in psychosis. *Schizophrenia research*, 85(1), 288-295.
- Jones, K. (1972) *A History of Mental Health Services*. London: Routledge
- Journal of Evidence-Based Complementary & Alternative Medicine* (JEBCAM). Available at: <http://chp.SAGEpub.com>. (Accessed on: 29.8.15)
- Kabat-Zinn, J. (1982) An outpatient programme in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General hospital psychiatry*, 4(1), 33-47.
- Kabat-Zinn, J. (2011) Some reflections on the origins of MBSR, skillful means, and the trouble with maps. *Contemporary Buddhism*, 12(01), 281-306.
- Kabat-Zinn, J. (2013) *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness*. Second Edition. London: Bantam/Random House
- Kaptchuk, T. (2001) The double-blind, randomized, placebo-controlled trial: Gold standard or golden calf? *Journal of Clinical Epidemiology*. 54, (6), 541–549
- Karuza J, Calkins E, Feather J, Hershey CD, Katz L, & Majeroni B. (1995) Enhancing physician adoption of practice guidelines: dissemination of influenza vaccination guideline using a small-group consensus process. *Archives Internal Medicine*;155:625–632
- Kelly, M., Morgan, A., Ellis, S., Younger, T., Huntley, J., & Swann, C. (2010) Evidence based public health: a review of the experience of the National Institute of Health and Clinical Excellence (NICE) of developing public health guidance in England. *Social science & medicine*, 71(6), 1056-1062.
- Kelly, M.P., Heath, I., Howick, J. & Greenhalgh, T., (2015) The importance of values in evidence-based medicine. *BMC medical ethics*, 16(1)
- Kemper, T.D. (ed.) (1990) *Research agendas in the sociology of emotions*. American Psychological Association. New York: SUNY Press.
- Keng, S. L., Smoski, M. J., & Robins, C. J. (2011) Effects of mindfulness on psychological health: A review of empirical studies. *Clinical psychology review*, 31(6), 1041-1056.
- Kenyon, E., & Hawker, S. (1999) 'Once would be enough': Some reflections on the

issue of safety for lone researchers. *International Journal of Social Research Methodology*, 2(4), 313-327.

Keyes, C. L. M. (2010) *Flourishing*. Corsini Encyclopedia of Psychology. Sussex: John Wiley & Sons

Khoury, B., Lecomte, T., Fortin, G., Masse, M., Therien, P., Bouchard, V. & Hofmann, S. G. (2013) Mindfulness-based therapy: A comprehensive meta-analysis. *Clinical Psychology Review*, 33(6), 763-771.

Kitzinger, J., & Williams, C. (2005) Forecasting science futures: Legitimising hope and calming fears in the embryo stem cell debate. *Social Science & Medicine*, 61(3), 731-740.

Kivits, J. (2013) *E-health and renewed sociological approaches to health and illness* in Orton-Johnson, K., & Prior, N. (ed) *Digital Sociology: Critical Perspectives*. Houndmills: Palgrave Macmillan, 213-226

Knaapen, L. (2013) Being evidence-based in the absence of Evidence: the management of non-Evidence in guideline development. *Social Studies of Science*, 43(5), 681-706

Knapp, M., McDaid, D., & Parsonage, M. (ed.) (2011) *Mental health promotion and mental illness prevention: The economic case*. Personal Social Services Research Unit, London School of Economics and Political Science. Available at: http://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/11/Knapp_et_al__MHPP_The_Economic_Case.pdf. (Accessed: 29.8.15)

Kopple, R. (2002) *Big players and the economic theory of expectations*. London: Palgrave

Koren, M. E., & Purohit, S. (2014) Interventional Studies to Support the Spiritual Self-Care of Health Care Practitioners: An Integrative Review of the Literature. *Holistic nursing practice*, 28(5), 291-300.

Krasner, M.S., Epstein, R.M., Beckman, H. (2009) Association of an educational programme in mindful communication with burnout, empathy, and attitudes among primary care physicians. *Journal of the American Medical Association*. 302(12):1284-1293.

Krieger, N. (2005) Embodiment: a conceptual glossary for epidemiology. *Journal of Epidemiology and Community Health*, 59(5), 350-355

Kuipers, E., Garety, P., Fowler, D., Freeman, D., Dunn, G., & Bebbington, P. (2006) Cognitive, emotional, and social processes in psychosis: refining cognitive behavioral therapy for persistent positive symptoms. *Schizophrenia Bulletin*, 32(suppl 1), S24-S31.

- Kumar, S., Feldman, G., & Hayes, A. (2008) Changes in mindfulness and emotion regulation in an exposure-based cognitive therapy for depression. *Cognitive Therapy and Research*, 32(6), 734-744.
- Kuyken, W., Byford, S., Taylor, R. S., Watkins, E., Holden, E., White, K. & Teasdale, J. D. (2008) Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *Journal of consulting and clinical psychology*, 76(6), 966.
- Kuyken, W., Hayes, R., Barrett, B., Byng, R., Dalgleish, T., Kessler, D. & Byford, S. (2015) Effectiveness and cost-effectiveness of mindfulness-based cognitive therapy compared with maintenance antidepressant treatment in the prevention of depressive relapse or recurrence (PREVENT): a randomised controlled trial. *The Lancet*. 4;386(9988):63-73
- Lakoff, G., & Johnson, M. (1999) *Philosophy in the flesh: The embodied mind and its challenge to Western thought*. New York: Basic books.
- Lama, D. (2005) *The universe in a single atom: The convergence of science and spirituality*. New York: Harmony.
- Lawton, J., Kirkham, J., White, D., Rankin, D., Cooper, C., & Heller, S. (2015) Uncovering the emotional aspects of working on a clinical trial: a qualitative study of the experiences and views of staff involved in a type 1 diabetes trial. *Trials*, 16(1), 3.
- Le Grand, J., & Robinson, R. (1984) *Privatisation and the welfare state*. London: Allen & Unwin.
- Leeder, S. R., & Rychetnik, L. (2001) Ethics and evidence-based medicine. *The Medical journal of Australia*, 175(3), 161-164.
- Lee-Treweek, G., & Linkogle, S. (2000) *Danger in the field: Risk and ethics in social research*. New York: Psychology Press.
- Leonard, D., & Sensiper, S. (1998) The role of tacit knowledge in group innovation. *California management review*, 40(3), 113.
- Leung, M. W., Yen, I. H., & Minkler, M. (2004) Community based participatory research: a promising approach for increasing epidemiology's relevance in the 21st century. *International journal of epidemiology*, 33(3), 499-506.
- Lewin, S., Glenton, C., & Oxman, A. (2009) Use of qualitative methods alongside randomised controlled trials of complex healthcare interventions: methodological study. *British Medical Journal*; 339: b3496
- Lewis, M. & Haviland-Jones, J. (2000) *Handbook of emotions*. New York: Guilford Press.
- Lewis, J., & Ritchie, J. (2003) Generalising from qualitative research. *Qualitative research practice: A guide for social science students and researchers*, 263-286.

- Liberman, R.P., Kopelowicz, A. (2002) Recovery from schizophrenia: a challenge for the 21st century. *International Review of Psychiatry*. 14:245-255
- Lilley, R., Whitehead, M., Howell, R., Jones, R., & Pykett, J. (2014) *Mindfulness Behaviour Change and Engagement in Public Policy*. Available at: <https://changingbehaviours.files.wordpress.com/2014/10/mbceppreport-1.pdf> (Accessed: 17.3.15)
- Little, J. M. (2002) Humanistic medicine or values-based medicine...what's in a name? *Medical journal of Australia*, 177(6), 319-322.
- Locock, L., Dopson, S., Chambers, D., & Gabbay, J. (2001) Understanding the role of opinion leaders in improving clinical effectiveness. *Social science & medicine*, 53(6), 745-757.
- Lomas, J., Enkin, M., Anderson, G. M., Hannah, W. J., Vayda, E., & Singer, J. (1991) Opinion Leaders vs audit and feedback to implement practice guidelines: delivery after previous cesarean section. *Journal of the American Medical Association*, 265(17), 2202-2207.
- Lovell, A., & Susser, E. (2014) What might be a history of psychiatric epidemiology? Towards a social history and conceptual account. *International Journal of Epidemiology*, 43 (suppl 1): i1-i5.
- Luchterhand, C. Rakel, D., Haq, C., Grant, L., & Byars-Winston, A. (2015) Creating a Culture of Mindfulness in Medicine. *Wisconsin Medical Society*. 114(3) 105-110
- Lucivero, F., & Prainsack, B. (2015) The lifestylisation of healthcare? 'Consumer genomics' and mobile health as technologies for healthy lifestyle. *Applied & Translational Genomics*, 4, 44-49
- Ludwig, D. S., & Kabat-Zinn, J. (2008) Mindfulness in medicine. *Journal of the American Medical Association*, 300(11), 1350-1352.
- Lupton, D. (1998) *The emotional self: A sociocultural exploration*. London: Sage.
- Lupton, D. (2012) M-health and health promotion: The digital cyborg and surveillance society. *Social Theory & Health*, 10 (3), 229-244.
- Lupton, D. (2013) Risk and emotion: Towards an alternative theoretical perspective. *Health, risk & society*, 15(8), 634-647.
- Lupton, D. (2015) Health promotion in the digital era: A critical commentary. *Health promotion international*, 30(1), 174-183.
- MacArtney, J. I., & Wahlberg, A. (2014) The Problem of Complementary and Alternative Medicine Use Today Eyes Half Closed?. *Qualitative health research*, 24(1); 114-123

- MacDonald, D., Barnes, M., Crawford, M., Omeni, E., Wilson, A., & Rose, D. (2014) Service user governors in mental health foundation trusts: accountability or business as usual?. *Health expectations*, 25. doi: 10.1111/hex.12274.
- Macmillan (2015) Available at: <http://www.macmillan.org.uk/information-and-support/coping/complementary-therapies/complementary-therapies-explained/psychological-self-help-therapies.html> (Accessed: 21.8.15)
- Maiese, M. (2014) How can emotions be both cognitive and bodily?. *Phenomenology and the Cognitive Sciences*, 13(4), 513-531.
- Malloch, K., Sluyter, D., & Moore, N. (2000) Relationship-centered care: achieving true value in healthcare. *Journal of Nursing Administration*, 30(7/8), 379-385
- Marinetti, C., Moore, P., Lucas, P., & Parkinson, B. (2011) Emotions in social interactions: Unfolding emotional experience in Cowie, R., Pelachaud, C., & Petta, P. (eds.) *Emotion-oriented systems* (pp. 31-46). Berlin: Springer.
- Markham, S. K. (1998) A longitudinal examination of how champions influence others to support their projects. *Journal of Product Innovation Management*, 15(6), 490-504.
- Martyn, D. (2002) Rethink report, *Self-management*. Available at: http://www.sirl.ie/other/repository_docs/34.pdf (Accessed: 28.1.13)
- Marx, R., Strauss, C., & Williamson, C. (2015) Mindfulness Apprenticeship: A new Model of NHS-Based MBCT Teacher Training. *Mindfulness*, 6(2), 253-263.
- Mason, J. (2002) *Qualitative researching*. London: SAGE.
- Mauthner, N. S., & Doucet, A. (2003) Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology*, 37(3), 413-431.
- May, C. (2006) A rational model for assessing and evaluating complex interventions in health care. *BMC health services research*, 6(1), 86.
- Mays, N. & Pope, C., (2000) *Assessing quality in qualitative research*. British Medical Journal; 320: 50.1
- McCabe, C., Claxton, K., & Culyer, A. J. (2008) The NICE cost-effectiveness threshold. *Pharmacoeconomics*, 26(9), 733-744.
- McNay, L. (1999) Gender, Habitus and the Field Pierre Bourdieu and the Limits of Reflexivity. *Theory, culture & society*, 16(1), 95-117.
- Mehling, W. E., Wrubel, J., Daubenmier, J. J., Price, C. J., Kerr, C. E., Silow, T., & Stewart, A. L. (2011) Body Awareness: a phenomenological inquiry into the common ground of mind-body therapies. *Philosophy, Ethics, and Humanities in Medicine*, 6(1), 6.
- Mehta, N. (2011) Mind-body dualism: A critique from a health perspective. *Mens sana monographs*, 9(1), 202.

- Mental Health Foundation (2012) '*Be Mindful*' course. Available at: <http://www.mentalhealth.org.uk/our-work/training/be-mindful-online-mindfulness-course> (Accessed: 19.10.12).
- Mental Health Foundation (2015) Available at: <http://www.mentalhealth.org.uk>. (Accessed: 24.3.15).
- Mental Health Research Network (MHRN) (2104). Available at: <http://www.invo.org.uk/find-out-more/invodirect-org/nih-mental-health-research-network> (Accessed: 20.10.14).
- Merleau-Ponty, M. (1962) *Phenomenology of Perception [Phénoménologie de la Perception]*. London: Routledge & Kegan Paul.
- Merleau-Ponty, M. (1996) *Phenomenology of Perception*. India: Shri Jainendra Press
- MHF online Mindfulness Course screenshot [image] (Mental Health Foundation 2015) Available: <http://bemindful.co.uk/> (Accessed: 10.8.14)
- Michael, M. (2000) Futures of the present: from performativity to prehension, in Brown, N., Rappert, B., & Webster, A. (ed.) *Contested futures: A sociology of prospective techno-science*. Aldershot: Ashgate.
- Mikulas, W. L. (2011) Mindfulness: Significant common confusions. *Mindfulness*, 2(1), 1-7.
- Miller, P., & Rose, N. (2008) *Governing the present: Administering economic, social and personal life*. London: Polity.
- Mills, N. (2010) *The Experience of Fragmentation in Psychosis: Can Mindfulness Help* in Clarke, I. (ed.). (2010) *Psychosis and spirituality: Consolidating the new paradigm*. Sussex: John Wiley & Sons. pp.211-221
- Milton, K. (2005) Emotion (or Life, the Universe, Everything). *The Australian Journal of Anthropology*. 16(2), 198–211
- MIND (2014). Available at: <http://www.mind.org.uk>. (Accessed: 23.4.14)
- Mind and Life Institute (2014) Available at: <https://www.mindandlife.org>. (Accessed: 7.3.14).
- Mind Apps.org (2014) Available at: <http://mindapps.org> (Accessed: 3.11.14).
- Mindful Living Programmes (2015) Available at: <http://www.mindfullivingprograms.com> (Accessed: 20.4.15).
- Mindful Psychiatry (2012) Available at: <http://mindfulpsychiatry.com>. (Accessed: 19.10.12)
- Mindfulness for Schools Project (2015) *What is .b?* Available at: <http://mindfulnessinschools.org/what-is-b> (Accessed: 5.5.15).
- Mindfulness Initiative (The) (2015) Available at:

- http://themindfulnessinitiative.org.uk/images/reports/Mindfulness-APPG-Report_Mindful-Nation-UK_Oct2015.pdf (Accessed: 23.4.16)
- Mindfulness publication covers (2014) [images] Available at: https://www.google.com/search?site=&tbm=isch&source=hp&biw=1366&bih=622&q=mindfulness+publications&oq=mindfulness+publications&gs_l=img.3..0j0i24.409.2476.0.3118.15.4.1.10.11.0.68.257.4.4.0....0...1ac.1.64.img..0.14.302.VDLvU0zzlkc#tbm=isch&q=mindfulness+front+covers. (Accessed 10.8.14)
- Mindfulness Teachers UK (2015) Available at: <http://mindfulnessteachersuk.org.uk/>. (Accessed: 18.7.15)
- Mindfulnet.org (2014) Available at: <http://www.mindfulnet.org>. (Accessed: 24.10.14)
- Mitchell, M., & Heads, G. (2015) Staying Well: A Follow Up of a 5-Week Mindfulness Based Stress Reduction Programme for a Range of Psychological Issues. *Community mental health journal*, 1-6.
- Mittman, B. (2004) Creating the evidence base for quality improvement collaboratives. *Annals of internal medicine*, 140(11); 897-901.
- Mockford, C., Staniszewska, S., Griffiths, F., & Herron-Marx, S. (2012) The impact of patient and public involvement on UK NHS health care: a systematic review. *International Journal for Quality in Health Care*, 24(1), 28-38.
- Mol, A. (1998) *Differences in medicine: Unraveling practices, techniques, and bodies*, 86-104. US: Duke University Press.
- Monaghan, L. (2001) Looking good, feeling good: the embodied pleasures of vibrant physicality. *Sociology of Health & Illness*. 23, (3), 330–356
- Moran, D. (2013) The Phenomenology of Embodiment: Intertwining and Reflexivity. In *The Phenomenology of Embodied Subjectivity* (pp. 285-303). Springer International Publishing.
- Moreira, T. (2005) Diversity in clinical guidelines: the role of repertoires of evaluation. *Social science & medicine*, 60(9), 1975-1985.
- Moreira, T. (2011) Health care rationing in an age of uncertainty: A conceptual model. *Social Science & Medicine*, 72(8), 1333-1341.
- Moreira, T. & Palladino, P. (2005) Between truth and hope: on Parkinson's Disease, neurotransplantation and the production of the 'self', *History of the Human Sciences*, 18(3), 55–82
- Morrison, A. (2001) The Interpretation of Intrusions in Psychosis: An Integrative Cognitive Approach to Hallucinations and Delusions. *Behavioural and Cognitive Psychotherapy*, 29, 257–276
- Morrison, L. G., Yardley, L., Powell, J., & Michie, S. (2012) What design features are used in effective e-health interventions? A review using techniques from Critical

- Interpretive Synstudy. *Telemedicine and e-health*, 18(2), 137-144.
- Muijs, D. (2010) *Doing Quantitative Research in Education with SPSS* (Google eBook). London: SAGE
- Muniesa, F., Millo, Y., & Callon, M. (2007) An introduction to market devices. *The sociological review*, 55(s2), 1-12.
- Murero, M., & Rice, R. E. (2013) *The Internet and health care: theory, research, and practice*. London: Routledge.
- Mykhalovskiy, E., & Weir, L. (2004) The problem of evidence-based medicine: directions for social science. *Social Science & Medicine*, 59(5), 1059-1069.
- National Institute for Health and Care Excellence (NICE) (2013) *Depression in adults: recognition and management*. Available at: <http://www.nice.org.uk/nicemedia/pdf/cg90niceguideline.pdf> (Accessed: 25.11.13)
- National Institute for Health Research (2013) *Spending Review*. Available at: http://www.nihr.ac.uk/about/Pages/About_Spending_Review.aspx. (Accessed: 28.1.13).
- National Institute for Mental Health in England (NIMHE) (2014) Available at: studymore.org.uk. (Accessed: 25.6.14).
- National Institute of Health and Care Excellence (2014) Available at: <http://www.nice.org.uk/nicemedia/pdf/cg90niceguideline.pdf> (Accessed: 1.10.14)
- National Service Framework for Mental Health (2015) Available at: <https://www.gov.uk/government/publications/quality-standards-for-mental-health-services>. (Accessed: 18.7.15)
- Neff, K. D. (2003) The development and validation of a scale to measure self-compassion. *Self and identity*, 2(3), 223-250.
- NESTA (2014) Available at: <http://www.nesta.org.uk>. (Accessed: 30.10.14)
- Nettleton, S. (2010) 'The Sociology of the Body' in Cockerham, W. (ed) (2010) *The New Blackwell Companion to Medical Sociology*. Oxford: Blackwell: pp. 47-69
- Neumann, P. J. (2009) Costing and perspective in published cost-effectiveness analysis. *Medical care*, 47(7_Supplement_1), S28-S32.
- New Savoy Partnership (<http://www.newsavoypartnership.org/>): 30.10.14
- Newnes, C., Holmes, G., & Dunn, C. (1999) *This Is Madness, A Critical Look at Psychiatry and the Future of Mental Health Services*. Herefordshire: PCCS Books
- NHS England (2014) Available at: <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>. (Accessed: 31.5.14)

- NHS England (2014) *Compassion in Practice – Two Years on*. Available at: <http://www.england.nhs.uk/wp-content/uploads/2014/12/nhs-cip-2yo.pdf>. (Accessed: 21.8.15)
- Nicholson, L. (2013) *Feminism/postmodernism*. London: Routledge.
- Nicolson, M.A. (2009) Nicholas Jewson and the disappearance of the sick man from medical cosmology, 1770-1870. *International Journal of Epidemiology*, 38 (3); 639-642.
- Nowotny, H. (2003) Democratising expertise and socially robust knowledge. *Science and public policy*, 30 (3); 151-156.
- Nunkoosing, K. (2005) The problems with interviews. *Qualitative health research*, 15(5), 698-706.
- Oakley, A. (2000) *Experiments in Knowing*. Cambridge: Polity Press
- O'Donnell, C. A. (2004) Attitudes and knowledge of primary care professionals towards evidence-based practice: a postal survey. *Journal of evaluation in clinical practice*, 10(2), 197-205.
- Oliver, D. (2014) Evidence based medicine needs to be more pragmatic. *British Medical Journal*, 349, g4453.
- Pagis, M. (2010) From abstract concepts to experiential knowledge: Embodying enlightenment in a meditation center. *Qualitative Sociology*, 33(4), 469-489
- Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2005) Realist review—a new method of systematic review designed for complex policy interventions. *Journal of health services research & policy*, 10(suppl 1), 21-34.
- Peile, E. (2013). Evidence-based medicine and values-based medicine: partners in clinical education as well as in clinical practice. *BMC medicine*, 11(1)
- Perkins R. (2001) What constitutes success? The relative priority of service users' and clinicians' views of mental health services. *British Journal of Psychiatry*, 179:9-10
- Perlman, H. H. (1957) *Social casework: A problem-solving process*. Chicago: University of Chicago Press.
- Petrik, A. M., & Cronin, T. J. (2014) Defining and Measuring Mechanisms of Change in Psychological Therapies: The Path Not Taken. *Australian Psychologist*, 49(5), 283-286.
- Phipps, A., & Bendelow, G. (2014) Body, Sociology of the, in Cockerham, W. (ed.) *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society*. London: Wiley-Blackwall
- Pickersgill, M. (2011) Promising' therapies: neuroscience, clinical practice, and the treatment of psychopathy. *Sociology of Health & Illness*, 33(3), 448-464

- Pickersgill, M. (2012) The Co-production of Science, Ethics, and Emotion. *Science Technology Human Values*. 37(6); 579-603
- Pilgrim, D. (2002) The biopsychosocial model in Anglo-American psychiatry: Past, present and future?. *Journal of Mental Health*, 11(6), 585-594.
- Pilgrim, R. (2008) Recovery' and current mental health policy. *Chronic Illness*. 4, 295–304
- Pilgrim, R. & Rogers, A. (2005) The Troubled Relationship between Psychiatry and Sociology. *International Journal of Social Psychiatry*. 51(3); 228–241
- Pilgrim, D. & Rogers, A. (2010) *A sociology of mental health and illness* (4th ed) Buckinghamshire: Open University Press
- Pixley, J. (2002) Finance organisations, decisions and emotions. *British Journal of Sociology*, 53, 1, 41-65
- Polanyi, M. (1958) *Personal knowledge, towards a post critical epistemology*. Chicago: University of Chicago Press
- Polgar, S., & Thomas, S. A. (2000) *Introduction to research in the health sciences*. Churchill Livingstone. New York.
- Pollock, A. (2011) Transforming the critique of Big Pharma. *BioSocieties*, 6(1), 106-118.
- Porter, M. E. (2010) What is value in health care?. *New England Journal of Medicine*, 363(26), 2477-2481
- Posadzki, P., Watson, L. K., Alotaibi, A., & Ernst, E. (2013) Prevalence of use of complementary and alternative medicine (CAM) by patients/consumers in the UK: systematic review of surveys. *Clinical medicine*, 13(2), 126-131.
- Potte-Bonneville, M. (2012) Michel Foucault's bodies. *Journal of the British Society for Phenomenology*, 43(1), 1-32.
- Potter, J., & Edwards, D. (2001) Discursive social psychology. *The new handbook of language and social psychology*, 9, 103-118.
- Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009) Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, 36(1), 24-34.
- Queen, C. S. (2000) *Engaged Buddhism in the west*. London: Simon and Schuster.
- Rabeharisoa, V. & Callon, M. (2002) The involvement of patients' associations in research. *International Social Science Journal*. 54(171);57–63
- Raftery, J. (2009) Should NICE's threshold range for cost per QALY be raised? No. *British Medical Journal*, 338.
- Rajan, K. S. (2006) *Biocapital: The constitution of postgenomic life*. Durham: Duke

University Press.

Rajan, K. S., & Leonelli, S. (2013) Introduction: Biomedical trans-actions, postgenomics, and knowledge/value. *Public Culture*, 25(3 71), 463-475.

Ramon, S., & Williams, J. E. (2005) *Mental health at the crossroads: the promise of the psychosocial approach*. Surrey: Ashgate.

Rapley, M., Moncrieff, J., & Dillon, J. (2011) *De-medicalizing misery: Psychiatry, psychology and the human condition*. London: Palgrave Macmillan

Räsänen, P., Roine, E., Sintonen, H., Semberg-Konttinen, V., Ryyänen, O. P., & Roine, R. (2006) Use of quality-adjusted life years for the estimation of effectiveness of health care: A systematic literature review. *International journal of technology assessment in health care*, 22(02), 235-241.

Regehr, C., Glancy, D., Pitts, A., & LeBlanc, V. R. (2014) Interventions to reduce the consequences of stress in physicians: a review and meta-analysis. *The Journal of nervous and mental disease*, 202(5), 353-359.

Reiner, K., Tibi, L., & Lipsitz, J. D. (2013) Do Mindfulness-Based Interventions Reduce Pain Intensity? A Critical Review of the Literature. *Pain Medicine*, 14(2), 230-242.

Rethink. (2015) *Complementary and alternative treatments – Types*. Available at: <http://www.rethink.org/diagnosis-treatment/treatment-and-support/complementary-and-alternative-treatments/types>. (Accessed: 21.8.15)

Reznek, L. (1991) *The philosophical defence of psychiatry*. London: Routledge

Rimé, B., 2007. Interpersonal emotion regulation. *Handbook of emotion regulation*, 1, pp.466-468.

Rogers, A., & Pilgrim, D. (2014) *A sociology of mental health and illness*. McGraw-Hill Education (UK).

Romme, M., & Escher, S. (1993) *Accepting voices*. London: MIND publications.

Romme, M., & Escher, S. (1994) Hearing voices. *British Medical Journal*., 309:670

Rose, N. (1992) Engineering the human soul: analyzing psychological expertise. *Science in Context*, 5, 2, 351-369

Rose, N. (1998) Governing risky individuals: the role of psychiatry in new regimes of control. *Psychiatry, Psychology and Law*, 3(2); 177-196

Rose, N. (2003) *The neurochemical self and its anomalies* (pp. 407-437). Toronto: University of Toronto Press.

Rose, N. (2006) *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton: Princeton University Press

Rottger-Rossler, B., & Markowitsch, H. J. (2009). *Emotions as bio-cultural processes*. New York: Springer

- Royal College of Physicians (2014) *Implementing NICE public health guidance for the workplace: a national organisational audit of NHS trusts in England*. Available at: https://www.rcplondon.ac.uk/sites/default/files/implementing_nice_web.pdf. (Accessed: 19.3.15)
- Royal Society (2011) *Transforming Behaviour Change*. Available at: <https://www.thersa.org/transforming-behaviour-change>. (Accessed: 3.11.14)
- Royal Society for the encouragement of Arts, Manufactures and Commerce's (RSAs) (2014) *Action Research Centre*. Available at: <https://www.thersa.org/about-us>. (Accessed: 30.10.14)
- Ruddle, A., Mason, O., & Wykes, T. (2011) A review of hearing voices groups: Evidence and mechanisms of change. *Clinical psychology review*, 31(5), 757-766.
- Russell, J., & Greenhalgh, T. (2014). Being 'rational' and being 'human': How National Health Service rationing decisions are constructed as rational by resource allocation panels. *Health*, 18(5), 441-457.
- Ryan-Flood, R., & Gill, R. (ed.) (2013) *Secrecy and silence in the research process: Feminist reflections*. London: Routledge.
- Rycroft-Malone, J., Anderson, R., Crane, R. S., Gibson, A., Gradinger, F., Griffiths, H. O. & Kuyken, W. (2014) Accessibility and implementation in UK services of an effective depression relapse prevention programme-mindfulness-based cognitive therapy (MBCT): ASPIRE study protocol. *Implementation Science*, 9(1), 62.
- Ryff, C. D., & Singer, B. H. (2008) Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of happiness studies*, 9(1), 13-39.
- Ryff, C.D. (1989) Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, 57(6), 1069-1081
- Ryff, C (2001) On Happiness and Human Potentials: A Review of Research on Hedonic and Eudaimonic Well-Being. *Annual Review of Psychology*. 52: 141-166
- Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996) Evidence based medicine: what it is and what it isn't. *British Medical Journal*. 312(7023), 71.
- Saks, M. (2003) Bringing together the orthodox and alternative in health care. *Complementary therapies in Medicine*, 11(3), 142-145.
- Sameroff, A. J., & Rosenblum, K. L. (2006) Psychosocial constraints on the development of resilience. *Annals of the New York Academy of Sciences*, 1094 (1), 116-124.
- Saukko, P. (2013) State of play in direct-to-consumer genetic testing for lifestyle-

- related diseases: market, marketing content, user experiences and regulation. *Proceedings of the Nutrition Society*, 72(01), 53-60.
- Scambler, G. (2002) *Health and Social Change, A Critical Theory*. Buckingham: Open University Press
- Scambler, G. (ed.) (2005) *Medical Sociology: The nature of medical sociology*. Oxon: Routledge
- Scheff, T. J. (1994) *Microsociology: Discourse, emotion, and social structure*. Chicago: University of Chicago Press.
- Scherer, K. R. (2011) On the rationality of emotions: or, When are emotions rational?. *Social Science Information*, 50(3-4), 330-350.
- Segal, Z. V., Teasdale, J. D., Williams, J. M., & Gemar, M. C. (2002) The mindfulness-based cognitive therapy adherence scale: inter-rater reliability, adherence to protocol and treatment distinctiveness. *Clinical Psychology & Psychotherapy*, 9(2), 131-138.
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002) *Mindfulness-based cognitive therapy for depression: A new approach to relapse prevention*. New York: Guilford.
- Segal, ZV., Kennedy, S., Gemar, M., Hood, K., Pedersen, R., Buis, T. (2006) Cognitive reactivity to sad mood provocation and the prediction of depressive relapse. *Archives General Psychiatry*, 63: 749–755
- Seidel, S., & Urquhart, C. (2013) On emergence and forcing in information systems grounded theory studies: the case of Strauss and Corbin. *Journal of information technology*, 28(3), 237-260.
- Sgroi Jr, A. (2014) *The Innovative Lean Machine: Synchronizing People, Branding, and Strategy to Win in the Marketplace*. Florida: CRC Press.
- Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2006) Mechanisms of mindfulness. *Journal of clinical psychology*, 62(3), 373-386.
- Shapiro, S.L., Brown, K.W., & Biegel, G.M. (2007) Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology*, 1(2), 105-115.
- Shaw, S., Rosen, R., & Rumbold, B. (2011) *What is integrated care?. An overview of integrated care in the NHS*. The Nuffield Trust. Available at:http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/what_is_integrated_care_research_report_june11_0.pdf (Accessed: 1.2.14)
- Sheldon, B. (2011) *Cognitive-behavioural therapy: Research and practice in health and social care*. London: Routledge.
- Sheldon, T. A., Cullum, N., Dawson, D., Lankshear, A., Lowson, K., Watt, I & Wright,

- J. (2004) What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews. *British Medical Journal*, 329(7473), 999
- Shilling, C. (2005). Embodiment, emotions, and the foundations of social order: Durkheim's enduring contribution, in Alexander, J., & Smith, P. (ed.) *The Cambridge Companion to Durkheim*, 211-238. Cambridge: Cambridge University Press
- Shonin, E., Van Gordon, W., & Griffiths, M. D. (2014) Meditation Awareness Training (MAT) for improved psychological well-being: a qualitative examination of participant experiences. *Journal of religion and health*, 53(3), 849-863.
- Shrira, A., Palgi, Y., Ben-Ezra, M., Spalter, T., Kavé, G., & Shmotkin, D. (2011) For better and for worse: The relationship between future expectations and functioning in the second half of life. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, gbq103.
- Sibthorpe, B. M., Glasgow, N. J., & Wells, R. W. (2005) Emergent themes in the sustainability of primary health care innovation. *Medical Journal of Australia*, 183(10), S77.
- Sieben, B., & Wettergren, A. (ed.) (2010) *Emotionalizing organizations and organizing emotions*. London: Palgrave Macmillan.
- Silverman, D. (2011) *Interpreting qualitative data: A guide to the principles of qualitative research*. Los Angeles, CA: SAGE.
- Singleton, V. (1998) Stabilizing Instabilities: the Role of the Laboratory in the United Kingdom Cervical Screening Programme, in Mol, A. (1998) *Differences in medicine: Unraveling practices, techniques, and bodies*, 86-104. US: Duke University Press.
- Sismondo, S. (2011) *An introduction to science and technology studies*. Sussex: John Wiley & Sons.
- Sjögren, E., & Helgesson, C. F. (2007) The Q (u) ALYfying hand: health economics and medicine in the shaping of Swedish markets for subsidized pharmaceuticals. *The Sociological Review*, 55(s2), 215-240.
- Smith, B., Fowler, D. G., Freeman, D., Bebbington, P., Bashforth, H., Garety, P. & Kuipers, E. (2006). Emotion and psychosis: links between depression, self-esteem, negative schematic beliefs and delusions and hallucinations. *Schizophrenia research*, 86(1), 181-188.
- Soares, M. O. (2012) Is the QALY blind, deaf and dumb to equity? NICE's considerations over equity. *British medical bulletin*, 101(1), 17-31.
- Sokol, D. K. (2013) "First do no harm" revisited. *British Medical Journal*, 347.
- Speed, E. (2006) Patients, consumers and survivors: A case study of mental health service user discourses. *Social science & medicine*, 62(1), 28-38.

- Spelman, E. V. (1988) *Inessential woman: Problems of exclusion in feminist thought*. Boston: Beacon Press.
- SPFT library (2014a) [image] *2014 SMC mindfulness conference*. In possession of: The author: Sussex
- SPFT library (2014b) [image] *Research poster of the M4V study*. In possession of: The author: Sussex
- SPFT library (2014c) [image] SPFT Research poster for *Low Intensity Guided Help Through Mindfulness* study. In possession of: The author: Sussex
- SPFT library (2015a) [image] *Promotional poster for the 2015 SMC Mindfulness conference*. In possession of: The author: Sussex
- SPFT library (2015b) [image] *Research poster of 2015 SPFT feasibility study and pilot RCT for Mindfulness-based Self Help (MBSH)*. In possession of: The author: Sussex
- SPFT library (2015c) [image] *Selection of SPFT research magazines*. In possession of: The author: Sussex
- SPFT library (2015d) [image] *SPFT Voices Clinic Research Poster*. In possession of: The author: Sussex
- SPFT Mindfulness Master Classes (2014) *SMC booking form for 2014 mindfulness Master Classes*. Available at: <http://www.sussexpartnership.nhs.uk/day-retreats-and-drop-ins> (Accessed: 17.8.14)
- SPFT Photographer (2014) [image] *Research and Development (R&D) Team*. In possession of: The author: Sussex
- SPFT Photographer (2014) Ruth Chandler, service user and carer involvement coordinator for SPFT [image] In possession of: The author: Sussex
- SPFT photographer (2014) Willem Kuyken and Chris Cullen, co-founder of the Mindfulness in Schools Project [image] In possession of: The author: Sussex
- SPFT website information for referrers to MBIs (2015) [image] *Sussex Partnership Mindfulness Practice: Information for Referrers*. Available at: <http://www.sussexpartnership.nhs.uk/mindfulness-practice> (Accessed: 16.7.15)
- Spring, B. (2007) Evidence-based practice in clinical psychology: What it is, why it matters; what you need to know. *Journal of Clinical Psychology*, 63(7), 611-631.
- Spyridonidis, D. & Calnan, M. (2012) Are new forms of professionalism emerging in medicine? The case of the implementation of NICE guidelines. *Health Sociology Review*. 20,(4): 394–409.
- Stam, H.J. (2010) Self and Dialogue Introduction. *Theory & Psychology*, 20(3); 299-304
- Stansfeld, S., & Candy, B. (2006) Psychosocial work environment and mental

health—a meta-analytic review. *Scandinavian journal of work, environment & health*, 32(6); 443-462.

Stenhouse, L. (ed.) (1980) *Curriculum research and development in action*. Heinemann Educational Publishers.

Sterne, J. (2003) Bourdieu, technique and technology. *Cultural Studies*, 17(3-4), 367-389.

Stewart, D., Wilson, R., Selby, P., & Darbyshire, J. (2011) Patient and public involvement. *Annals of oncology*, 22(7), 54-56.

Stewart, R. E., & Chambless, D. L. (2007) Does psychotherapy research inform treatment decisions in private practice?. *Journal of clinical psychology*, 63(3), 267-282.

Stone, M. (2014) Abusing the Buddha: How the US Army and Google co-opt mindfulness. *Salon*, 17, 14.

Summerfield, D. & Veale, D. (2008) Proposals for massive expansion of psychological therapies would be counterproductive across society. *British Journal of Psychiatry* 192:326-330

Sussex Community NHS (2015) *Get Involved*. Available at: sussexcommunity.nhs.uk/get-involved. (Accessed: 3.5.15)

Sussex Mindfulness Centre (2015) Available at: <http://www.sussexpartnership.nhs.uk/activities-sussex-mindfulness-centre>. (Accessed: 25.8.15)

Sussex Partnership *Children & Adult Mental Health Services (CAMHS)* (2015) Available at: <http://www.sussexpartnership.nhs.uk/mindfulness-camhs> (Accessed: 20.8.15)

Sussex Partnership *Compassion Circles* (2015) Available at: http://www.sussexpartnership.nhs.uk/sites/default/files/media/frameworks_4_change.pdf. (Accessed: 20.5.15)

Sussex Partnership *Expert Patient Programme* (2015) Available at: http://www.sussexcommunity.nhs.uk/get-involved/expert_patients_programme.htm. (Accessed: 3.5.15)

Sussex Partnership Foundation Trust website homepage (2014) [image] Available at: <http://www.sussexpartnership.nhs.uk>. (Accessed: 4.10.14)

Sussex Partnership *Lived Experience Advisory Panel (LEAP)* (2014) Available at: <http://www.sussexpartnership.nhs.uk/r-and-d/involvement/leap>. (Accessed: 20.10.14)

- Sussex Partnership Mindfulness Based Cognitive Therapy (2015) [image] *Screenshot from SPFT website setting out the benefits of MBCT*. Available at: <http://www.sussexpartnership.nhs.uk/mindfulness-practice> (Accessed: 16.7.15)
- Sussex Partnership *Mindfulness Practice* (2014) Available at: <http://www.sussexpartnership.nhs.uk/mindfulness-practice> (Accessed: 8.6.14)
- Sussex Partnership *Mindfulness Practice: Information for Referrers* (2015) Available at: <http://www.sussexpartnership.nhs.uk/mindfulness-practice> (Accessed: 8.4.15)
- Sussex Partnership *Mindfulness Research* (2014) Available at: <http://www.sussexpartnership.nhs.uk/gps/education/smc/mindfulness-research>. (Accessed: 30.5.14)
- Sussex Partnership Mindfulness Training (2015) [image] *Promotional information for Mindfulness groups for SPFT staff*. Available at: <http://www.sussexpartnership.nhs.uk/mindfulness-training>. (Accessed: 16.7.15)
- Sussex Partnership Mindfulness Teacher Training Programme (2015) Available at: <http://www.sussexpartnership.nhs.uk/mindfulness-training>. (Accessed: 3.3.15)
- Sussex Partnership NHS Trust *Mindfulness Groups for Staff* (2015) Available at: <http://www.sussexpartnership.nhs.uk/mindfulness-groups-staff>. (Accessed: 31.3.15)
- Sussex Partnership Operational Plan (2015) *Operational Business Plan for y/e 31 March 2015 and 2016*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340237/SUSSEXPART_Operational_Plan_14-16_1_.pdf. (Accessed: 3.3.15)
- Sussex Partnership *Patient Experience* (2015) Available at: <http://www.sussexpartnership.nhs.uk/patient-experience>. (Accessed: 16.3.15)
- Sussex Partnership Research Magazine (2015) Available at: http://www.sussexpartnership.nhs.uk/sites/default/files/documents/research_mag_5.pdf. (Accessed: 16.6.15)
- Sussex Partnership Trust Research (2015) [image] *Screenshot from SPFT website showing the Trust's research and development partnerships*. Available at: <http://www.sussexpartnership.nhs.uk/research>. (Accessed: 2.3.15)
- Sussex Psychosis Research interest Group (SPRiG) (2015) *Mindfulness for Voices (M4V)*. Available at: <http://www.sussex.ac.uk/spriglab/research/current/prodigy>. (Accessed: 24.3.15)
- Sutton, M. (1997) How to get the best health outcome for a given amount of money. *British Medical Journal*. 315:47–49
- Swartz, D. (2012) *Culture and Power: The Sociology of Pierre Bourdieu*. Chicago: University of Chicago Press

- Szasz, T. S. (1960) The myth of mental illness. *American Psychologist*, 15(2), 113.
- Tattersall, R. (2002) The expert patient: a new approach to chronic disease management for the twenty-first century. *Clinical Medicine*, 2(3), 227-229.
- Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000) Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of consulting and clinical psychology*, 68(4), 615.
- Teasdale, J. D., Segal, Z., & Williams, J. M. G. (1995) How does cognitive therapy prevent depressive relapse and why should attentional control (mindfulness) training help?. *Behaviour Research and therapy*, 33(1), 25-39.
- Theodosius, C. (2006) Recovering Emotion from Emotion Management. *Sociology*. 40 (5), 893-910
- Theodosius, C. (2008) *Emotional Labour in Health Care- The Unmanaged Heart of Nursing*. Oxon: Routledge
- Thomas, P., & Bracken, P. (2004) Critical psychiatry in practice. *Advances in Psychiatric Treatment*, 10(5), 361-370.
- Thompson, M. (2007) Innovation in work practices: a practice perspective. *The International Journal of Human Resource Management*, 18(7), 1298-1317.
- Tierney, E., McEvoy, R., O'Reilly-de Brún, M., Brún, T., Okonkwo, E., Rooney, M. & MacFarlane, A. (2014) A critical analysis of the implementation of service user involvement in primary care research and health service development using normalization process theory. *Health Expectations*. Jul 24. doi: 10.1111/hex.12237.
- Timmermans, S., & Mauck, A. (2005) The promises and pitfalls of evidence-based medicine. *Health Affairs*, 24(1), 18-28.
- Todres, L., Galvin, K. T., & Holloway, I. (2009) The humanization of healthcare: A value framework for qualitative research. *International Journal of Qualitative Studies on Health and Well-being*, 4(2), 68-77.
- Tong, A., Sainsbury, P., & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349-357.
- Towse, A. (2009) Should NICE's threshold range for cost per QALY be raised? Yes. *British Medical Journal*, 338:b181
- Tran, V. (1998) The role of the emotional climate in learning organisations. *The Learning Organization*. 5 (2), 99-103
- Treynor, W., Gonzalez, R., & Nolen-Hoeksema, S. (2003) Rumination reconsidered: A psychometric analysis. *Cognitive Therapy and Research*, 27(3), 247-259.
- Turkle, S. (2011) *Life on the Screen*. London: Simon and Schuster.

- Turner, B. (1992) *Regulating Bodies: Essays in Medical Sociology*. London: Routledge
- Turner, B. S. (2008) *The body and society: Explorations in social theory*. London: SAGE.
- Turner, J. H., & Stets, J. E. (2005) *The sociology of emotions*. Cambridge: Cambridge University Press.
- Vacharkulksemsuk, T., Sekerka, L. E., & Fredrickson, B. L. (2011) Establishing a positive emotional climate to create 21st-century organizational change. *The handbook of organizational culture and climate*, 2, 101-118.
- Valente, T. W. (1995) *Network models of the diffusion of innovations* (Vol. 2, No. 2). New Jersey: Hampton Press.
- Valente, T. W., & Pumpuang, P. (2007) Identifying opinion leaders to promote behavior change. *Health Education & Behavior*. 34(6):881-96
- Valuation Studies (2015) Available at: <http://valuationstudies.liu.se>. (Accessed: 16.4.15)
- Van Dam, N. T., Earleywine, M., & Danoff-Burg, S. (2009) Differential item function across meditators and non-meditators on the Five Facet Mindfulness Questionnaire. *Personality and Individual Differences*, 47(5), 516-521.
- van der Velden, A.M. and Roepstorff, A., 2015. Neural mechanisms of mindfulness meditation: bridging clinical and neuroscience investigations. *Nature Reviews Neuroscience*, 16(7), pp.439-439.
- van der Watt, G., Laugharne, J., & Janca, A. (2008) Complementary and alternative medicine in the treatment of anxiety and depression. *Current Opinion in Psychiatry*, 21(1), 37-42.
- van Loon, E., Zuiderent-Jerak, T., & Bal, R. (2014) Diagnostic Work through Evidence-Based Guidelines: Avoiding Gaps Between Development and Implementation of a Guideline for Problem Behaviour in Elderly Care. *Science as Culture*, 23(2), 153-176.
- van Ravesteijn, H., Lucassen, P. L. B. J., Bor, H., Van Weel, C., & Speckens, A. (2013) Mindfulness-based cognitive therapy for patients with medically unexplained symptoms: a randomized controlled trial. *Psychotherapy and psychosomatics*, 82(5), 299-310.
- Verdoux, H., & van Os, J. (2002) Psychotic symptoms in non-clinical populations and the continuum of psychosis. *Schizophrenia research*, 54(1), 59-65.
- Wacquant, L. (2014) Putting Habitus in its Place: Rejoinder to the Symposium. *Body & Society*, 20; 2118-139

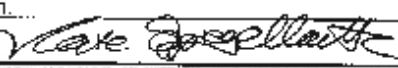
- Wainwright, D., & Calnan, M. (2002) *Work stress: The making of a modern epidemic*. McGraw-Hill Education (UK).
- Waller, H., Garety, P. A., Jolley, S., Fornells-Ambrojo, M., Kuipers, E., Onwumere, J. & Craig, T. (2013) Low intensity cognitive behavioural therapy for psychosis: a pilot study. *Journal of behavior therapy and experimental psychiatry*, 44(1), 98-104.
- Walters, K., Buszewicz, M., Weich, S., & King, M. (2008) Help-seeking preferences for psychological distress in primary care. *British Journal of General Practice*, 58(555), 694-698.
- Wanless, D. (2002) *Securing our future health: taking a long-term view*. London: HM Treasury, 16.
- Ward, P. R., Thompson, J., Barber, R., Armitage, C. J., Boote, J. D., Cooper, C. L., & Jones, G. L. (2010) Critical perspectives on 'consumer involvement' in health research Epistemological dissonance and the know-do gap. *Journal of Sociology*, 46(1), 63-82.
- Watts, D. J., & Dodds, P. S. (2007). Influentials, networks, and public opinion formation. *Journal of consumer research*, 34(4), 441-458.
- Weiss, G., & Haber, H. F. (1999) *Perspectives on embodiment: the intersections of nature and culture*. Cambridge: Cambridge University Press
- Welch, P., Thomas, C., & Bingley, A. (2013) Working at the coalface: Using action research to study 'integrative medicine' in the NHS. *European Journal of Integrative Medicine*, 5(1), 75-82.
- Welsh, E. (2002) Dealing with data: Using NVivo in the qualitative data analysis process, in *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 3(2).
- West, M., & Dawson, J. (2012) Employee engagement and NHS performance. *The King's Fund*, 1-23.
- What Works Network (2014) Available at: <https://www.gov.uk/guidance/what-works-network>. (Accessed: 30.10.14)
- White, T. P., Wigton, R. L., Joyce, D. W., Bobin, T., Ferragamo, C., Wasim, N. & Shergill, S. S. (2014) Eluding the illusion? Schizophrenia, dopamine and the McGurk effect. *Frontiers in human neuroscience*, 8.
- Whitley, R., & Crawford, M. (2005) Qualitative research in psychiatry. *Canadian journal of psychiatry*, 50(2), 108-114.
- Widdicombe, S., & Wooffitt, R. (1995) *The language of youth subcultures: Social identity in action*. New York: Harvester Wheatsheaf

- Wiese, M., Oster, C., & Pincombe, J. (2010) Understanding the emerging relationship between complementary medicine and mainstream health care: A review of the literature. *Health*, 14(3), 326-342.
- Will, C. & Moreira, T. (ed.) (2012) *Medical proofs, social experiments: Clinical trials in shifting contexts*. Farnham: Ashgate Publishing, Ltd.
- Wilkinson, J., & Gale, N. K. (2015) Adapting clinical governance for complementary and alternative medicine in Gale, N. K. and McHale, J. V. (eds.) *Routledge Handbook of Complementary and Alternative Medicine. Perspectives from Social Science and Law*. London: Routledge, 341.
- Wilkinson, J., & Gale, N. K. (2015) Towards a Learning Profession? In Gale, N. K. and McHale, J. V. (ed.) (2015) *Routledge Handbook of Complementary and Alternative Medicine. Perspectives from Social Science and Law*. London: Routledge
- Will, C. (2010) The management of enthusiasm: motives and expectations in cardiovascular medicine. *Health*, 14 (6); 547-563
- Williams, J. & Ramon, S. 'Mental Health at the Crossroads', in Ramon, S. & Williams, J. (ed.) (2005) *Mental Health at the Crossroads: The Promise*. Aldershot: Ashgate Publishing: 13-25
- Williams, M., & Penman, D. (2011). *Mindfulness: a practical guide to finding peace in a frantic world*. Hachette UK.
- Williams, S. & Bendelow, G. (1996) The Emotional Body. *Body & Society*. 2: 125
- Williams, S. (2000) Reason, emotion and embodiment: is 'mental' health a contradiction in terms?. *Sociology of Health & Illness*, 22(5), 559-581.
- Williams, S. (2003) *Medicine and the Body*. London: SAGE.
- Williams, S. (2006) Medical sociology and the biological body: where are we now and where do we go from here?. *Health*., 10(1), 5-30.
- Williams, S. J. (1995) Theorising class, health and lifestyles: can Bourdieu help us?. *Sociology of health & illness*, 17(5), 577-604.
- Williams, S. J., & Bendelow, G. (1998) Introduction: emotions in social life: mapping the sociological terrain. *Emotions in social life: Critical themes and contemporary issues*. London: Routledge.
- Williams, S. J., Gabe, J., & Davis, P. (2008) The sociology of pharmaceuticals: progress and prospects. *Sociology of health & illness*, 30(6), 813-824.
- Williams, S., & Monaghan, G. 'Embodiment' in Gabe & Monaghan ed. (2013) Second ed. *Key Concepts in Medical Sociology*. London: SAGE: 66-67
- Williams, S., Gabe, J., & Calnan, M. (ed) (2000) *Health, Medicine and Society. Key Theories, Future Agendas*. Oxon: Routledge

- Williamson, L. (2014) Patient and citizen participation in health: The need for improved ethical support. *The American Journal of Bioethics*, 14(6), pp.4-16.
- Witz, A. (2000) Whose body matters? Feminist sociology and the corporeal turn in sociology and feminism. *Body & society*, 6(2), 1-24.
- Wolkowitz, C. (2002) The social relations of body work. *Work, Employment & Society*, 16(3), 497-510.
- Wonderling, D., Sawyer, L., Fenu, E., Lovibond, K., & Laramée, P. (2011). National clinical guideline centre cost-effectiveness assessment for the national institute for health and clinical excellence. *Annals of internal medicine*, 154(11), 758-765
- World Health Organisation (2012) 'E-health' (<http://www.who.int/topics/e-health/en/>): 25.7.14
- Yin, R. (2013) *Case Study Research: Design and Methods* (5th ed) SAGE.
- Zeidan, F., Grant, J. A., Brown, C. A., McHaffie, J. G., & Coghill, R. C. (2012) Mindfulness meditation-related pain relief: evidence for unique brain mechanisms in the regulation of pain. *Neuroscience letters*, 520(2), 165-173.
- Zola, I. K. (1972) Medicine as an institution of social control. *The Sociological Review*, 20(4), 487-504.

APPENDICES

1. Research passport issued by SPFT (first page):

Research Passport			
Please refer to the guidance notes before completing the form.			
Section 1 - Details of Researcher To be completed by Researcher			
1. Surname: Spiegelhalter		Prof <input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/>	
Forename(s): Kate Lauren		Miss <input type="checkbox"/> Ms <input checked="" type="checkbox"/> Other <input type="checkbox"/>	
Home Address: 43 Scotland Street, Brighton, BN2 9WA			
Work Address/Place of Study: University of Sussex			
Work Tel:		Mobile: 07828597173	Email: k.l.spiegelhalter@sussex.ac.uk
2. Date of birth: 11/12/1982		Gender: Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>	
Ethnicity: White (British)		National Insurance number: JT 26 57 54 C	
3. Professional registration details (if applicable): N/A <input checked="" type="checkbox"/>			
4. Employer: or place of study: University of Sussex, Falmer, BN1 9RH			
Post or status held: PhD researcher, Sociology Department			
Section 2 - Details of Research To be completed by Researcher			
5. What type of Research Passport do you need? Project-specific <input checked="" type="checkbox"/> Three-year <input type="checkbox"/>			
If you will be conducting only one project please complete the details below. If you will be undertaking more than one project at any one time, please give details in the Appendix.			
Project Title: A critical analysis of the mindfulness agenda in Sussex			
Project Timetable: Start Date: 10/11 End Date: 10/14			
NHS organisation(s):	Dept(s):	Proposed research activities:	Manager in NHS organisation:
Sussex Partnership NHS Foundation Trust	Research and Development	Qualitative Research alongside the 'M4V' RCT being run by the Trust.	Tim Telling
Section 3 - Declaration by Researcher To be completed by Researcher			
6. Have you ever been refused an honorary research contract?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Have you ever had an honorary research contract revoked?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
If yes to either question, please give details:			
I consent to the information requested in this Research Passport (including attached documents) being processed and held by authorised staff of the NHS organisations where I will be conducting research.			
Signed: 		Date: 13/09/2012	
When Sections 1-3 have been completed, the researcher should forward the form to the appropriate person to complete Section 4.			

2. Research Journal extracts

Description of event, thought, meeting:	
Sussex Research in Development seminar on 18.4.12	Analysis of my response, reflection on event
<ul style="list-style-type: none"> - If going with <i>Nudge</i> I don't need to appear to be an advocate, but can just say that 'X' <i>seems to work</i> from the evidence. - Keep it sociological and relate to current studies in this field rather than clouding it with complication psycho-social and psychology studies. - Number of interviewees cannot be specified yet but to bear in mind that I shouldn't have my focus distracted by trying to get hold of GPs when it is the user's narratives that I am primarily interested in. - From the practitioners it is the utility and efficacy of mindfulness provision that I want to find out. - That calling my study 'action research' is over egging the cake...this would need to include an implemented change which was then evaluated. I can effect change through my recommendations. - Take into account how cultural behaviours may be affecting attitudes towards both nudge and mindfulness. 	<ul style="list-style-type: none"> - Really useful comments (still found I had nerves and slight lack of confidence about how tight my plan is and the outcome measures); especially in terms of the effect the label of '<i>nudge</i>' has on practitioners and health promotion workers. *****'s comment on focusing on the narratives of users as the strength of the study. I should either trust the M4V evaluation or not. I need to trust the testimony of the people who have been through it. - Make sure I bring in the socioeconomic angle (people at the margins should be the focus - psychosis). I need to take into account the many confounding variables which might make a mindfulness course work (drugs, love, family, home, job...) (use for QCA?!). I will be trusting the narrative over the medical explanation and will assume that mindfulness is the key motivator of change and then see what comes from the data.

Description of event, thought, meeting:	
Meeting at Sussex House with M4V	Analysis of my response, reflection

study team on 22.8.12 regarding details of my involvement	on event
<ul style="list-style-type: none"> - Changed title to 'Sussex' not 'East Sussex', as **** highlighted that there is not any justification for limiting my study to this area. - LEAP are no longer a separate work package, as asking this population on their views on mindfulness is not well mapped enough to justify, is too much of a random allocation amidst the structured samples of the other work packages. I can use LEAP to consult on possible promotional materials in the future though according to Ruth. - Paul Chadwick, the CI of the M4V study, does not want any PO taking place the study, as this might compromise the therapeutic alliance of the groups. ***** and ***** agreed that they had 'missed out on a trick' by not seeking permission to record any of the sessions for analysis and learning opportunities. - **** and **** did not feel that the questions and focus groups about possible nudges were relevant or suitable for M4V participants. - Added mindfulness course facilitators and members of the M4V team to Work Package 5: other stakeholders. - Possible different options about joint 	<ul style="list-style-type: none"> - Useful discussion when asked to outline my study for them: need to be very clear about my line of enquiry in the overlap with M4V and psychosis. It was good to hear that ***** thought that asking other stakeholders about their views on Mindfulness for psychosis was worthwhile. - The nudge aspect of my study has been further pushed to the side with the exclusion of this angle in the M4V interviews, as has the participant observation of the M4V groups. - Feel slight concern about possible delays which the changes to ethics REC documents might cause. - Waiting for Ruth's feedback on my topic guide now, will see how much my own research questions might be compromised by LEAP feedback and how this might affect the comparability between my different work packages. - Need to add Hampshire now as a separate SSI form on IRAS now that am interviewing study participants from there. - My data collection can only start once the final data has been collected on M4V after the 6 month follow-up, this means

interviewing/dividing of questions between myself and the lived experience peer researchers trained by Ruth (or seeing LEAP's analysis as a sub-set of mine). I do not want to take over but would like some contact with the study participants if possible. After discussion of the various options it was decided that amalgamation of mine and the LEAPs topic guides was the best way forward. This would also be better for the study as part of the portfolio as **** pointed out. This method would also better utilise the peer researchers, and (hopefully) allow more ground to be covered by doubling the man-power. Joint analysis would also be carried out by myself and the M4V team (inc. the LEAP).

- The above methodology may act as a pilot for Ruth's PhD interest in the possible different responses to be got from clinical and non-clinical data collectors. I am not a clinical interviewer, but data could still possibly be useful on variations between lived and non-lived experience (a secondary question within this aim).

that I should focus on other groups before that time (around Feb/March 2013). There are 3 'waves' to come of M4V groups. The newly agreed methodology can be piloted on the first group then tinkered with on the second (Grounded Theory). Go through ***** and ***** to access clinicians and referrers, and do this in sync with M4V participants.

- Need to begin a strict timing schedule of aims and deadlines for interviews for the different work package interviews.

- Joint analysis: the same data set can be analysed critically and uncritically. Re: ethics need a plan for distress for participants and the peer researchers, need to coordinate with Ruth on the wording for this in the REC.

- Grounded theory: I was pleased to hear **** say that it would lend itself to finding themes across a range of stakeholders.

- Questions for GPs/Health professionals: ***** said to be careful - ask about sustainable outcomes from referring patients, and their role in helping X to sustain these outcomes.

- Sussex Mindfulness Centre: ***** said I could have a page on the website and that my research might be able to feed into their work.

3. Consent form used for M4V interviews

Date: 25/05/2012

Reference: 12/LO/0978



Research & Development
Sussex Education Centre
Millview Hospital, Nevill Avenue
Hove BN3 7HZ
Tel: 01273 265928

Email: Research@sussexpartnership.nhs.uk

CONSENT FORM

Title of Project: *Creative approaches to mental health: a critical analysis of the mindfulness agenda in Sussex*

Name of Researcher: Kate Spiegelhalter

Please
initial box

I confirm that I have read and understand the information sheet dated 25/05/2012 (12/LO/0978) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐

I agree to take part in the above study.

☐

I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be treated in accordance with the terms of the Data Protection Act 1998

☐

I understand that my words may be directly quoted in the report but I will not be identified.

☐

I would prefer to be interviewed by: Peer researcher

☐

PhD student

☐

I consent to be asked about future research in this area in the future.

☐

Name of Participant

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

Kate Spiegelhalter/LPS/Sociology/Doctoral Researcher
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T +44 (0)7828597173 • E k.i.spiegelhalter@sussex.ac.uk •
<http://www.sussex.ac.uk/sociology/people/peoplelists/person/144720>

4. Online survey for SPFT clinicians:**Mindfulness therapies in Sussex - SPFT staff survey**

This survey is part of ESRC-funded doctoral research mapping mindfulness services in Sussex, please see the attached information sheet for further details about this study. The study has had full ethical approval, and should take less than 15 minutes to complete. All answers will be entirely confidential and anonymous. At the bottom of the questionnaire will be an option to be contacted for a face to face interview. Your responses and time will be gratefully received.

1.

Mark only one oval.☐ Option 1

2.

1. Are you male or female?*Mark only one oval.*☐ Male☐ Female

3.

2. What is your place of work and location in Sussex?*Mark only one oval.*☐ Single practice☐ Health Centre☐ Polyclinic☐ CMHT☐ Psychiatric Hospital

4.

3. What is your age?*Mark only one oval.*☐ 20-29☐ 30-39☐ 40-49☐ 50-59☐ 60-69☐ 70-79☐ 80-89

5.

4. Are you aware of mindfulness-based cognitive therapy (MBCT)?*Mark only one oval.*☐ Yes☐ No

6.

5. Are you aware of mindfulness-based stress reduction (MBSR)?*Mark only one oval.*☐ Yes☐ No

7.

6. Have you ever been on a mindfulness course?*If you answered Yes complete questions 7 to 11, if No go to question 12**Mark only one oval.*☐ Yes☐ No

8.

7. How did you find out about the mindfulness course you attended?*Mark only one oval.*☐ A colleague☐ The internet☐ Family or friends☐ Other:

9.

8. What were your reasons for attending the mindfulness course?*Mark only one oval.*☐ To reduce stress☐ To feel happier and more content☐ Pain or illness☐ Because it was recommended to you☐ Other:

10.

9. Has being on the course(s) affected your relationship with your body in any way?

.....

.....

.....

.....

.....

11.

10. Has being on the course affected your ability to cope/deal with difficulties in day to day life?

12.

11. Are there any other differences it has made or comments on the experience as a whole?

13.

12. Do you see mindfulness as being a popular therapy at the moment?

If Yes complete questions 13 and 14, if No go to question 15

Mark only one oval.

☐ Yes

☐ No

14.

13. If so, with which groups do you see mindfulness as being popular?

Mark only one oval.

☐ Politicians and policy makers

☐ Members of the public

☐ Mental health service users

☐ GPs

☐ Other: _____

15.

14. How would you explain, or to what would you attribute, this popularity with any of the specific groups in question 13?

16.

15. Are you aware that mindfulness courses are also run online?*Mark only one oval.*☐ Yes☐ No

17.

16. Have you ever referred any of your patients to a mindfulness-related therapy course such as MBCT or MBSR or encourage them to attend?*Mark only one oval.*☐ Yes☐ No

18.

17. If you have referred, please specify to which therapy (MBCT, MBSR or an online course) and your reason(s) for referral*Optional to specify what the person had e.g. depression/anxiety etc. Please maintain patient confidentiality/data protection*

19.

18. If you answered no to question 16, would you consider referring in the future?*Mark only one oval.*☐ Yes☐ No

20.

19. If you would consider referring in the future, would you choose to refer to an online or a face-to-face course?*Mark only one oval.*☐ Online☐ Face-to-face

21.

20. If you would consider referring or recommending, would you know to which service or provider?*Mark only one oval.*☐ Yes☐ No

22.

21. If yes, what is the name of the provider to which you would refer or recommend?

23.

22. What would be the factors taken into consideration when deciding whether or not to refer or recommend?

24.

23. Are you aware of the new Sussex Mindfulness Centre?

Mark only one oval.

- ☐ Yes
- ☐ No

25.

24. Are you aware of the 'Mindfulness for Voices (M4V)' study currently being run within the Research & Development Department at Sussex Partnership NHS Foundation Trust?

Mark only one oval.

- ☐ Yes
- ☐ No

26.

25. Do you think that a mindfulness course might be useful for people who experience psychosis or hear distressing voices?

Mark only one oval.

- ☐ Yes
- ☐ No
- ☐ Other: _____

27.

26. Would you consider referring/recommending a patient you were seeing who was experiencing psychosis to attend a mindfulness course?

Mark only one oval.

☐

Yes

☐

No

☐

Other: _____

28.

27. Do you think mindfulness should be offered to patients on the NHS?

Mark only one oval.

☐

Yes

☐

No

29.

28. If you answered yes to question 27, to whom do you think mindfulness should be provided:

Mark only one oval.

☐

Existing users of mental health services

☐

Those with a long-term or debilitating chronic physical illness

☐

Everyone according to need

☐

Other: _____

30.

29. Are you aware of the 'nudge' agenda or the Behavioural Insights Team?

Mark only one oval.

☐

Yes

☐

No

☐

Other: _____

31.

30. If you answered yes to question 29, would you consider this area of behavioural economics applicable to mindfulness therapies in terms of increasing take-up and attendance rates of MBCT or MBSR courses?

If you answered no to the previous question, please skip this question.

32.

31. Do you see any of the following possible 'nudges' as potentially useful or effective:*Mark only one oval.*

- ☐ The adaptation of current promotional materials using different language and framing
- ☐ Adapted follow-up peer support structures (following the NICE Guidelines for Peer Support for Mental Sickness CG123) using physical spaces and online forums
- ☐ Increase awareness of mindfulness training among GPs, therapists, Trust staff and others
- ☐ Adaption of the language used in one-to-one or group mindfulness settings
- ☐ Improve evaluative forms and mechanisms
- ☐ Other:

33.

32. How important are NICE guidelines in your daily work?*Mark only one oval.*

- ☐ Not very important
- ☐ Slightly important
- ☐ Not sure
- ☐ Quite important
- ☐ Very important

34.

33. How important is the DSM in your daily work?*Mark only one oval.*

- ☐ Not very important
- ☐ Slightly important
- ☐ Not sure
- ☐ Quite important
- ☐ Very important

35.

34. Do you feel you keep up to date with the latest research developments in medicine?*Mark only one oval.*

- ☐ Yes
- ☐ No
- ☐ Other:

36.

35. Where do you feel you get/are most likely to get useful information about research that may be relevant to your practice?

Mark only one oval.

- ☐ Team meetings
- ☐ Research magazine
- ☐ From your peers one a one-one or adhoc basis
- ☐ Email updates
- ☐ Other:

37.

36. Do you have any further comments?

.....

38.

37. How would you describe your ethnic origin?

Mark only one oval.

- ☐ White - British
- ☐ White - Irish
- ☐ Other White background
- ☐ Black or Black British - Caribbean
- ☐ Black or Black British - African
- ☐ Other Black background
- ☐ Asian or Asian British - Indian
- ☐ Asian or Asian British - Pakistani
- ☐ Asian or Asian British - Bangladeshi
- ☐ Chinese or other Ethnic background
- ☐ Other Asian background
- ☐ Mixed - White and Black Caribbean
- ☐ Mixed - White and Black African
- ☐ Mixed - White and Asian
- ☐ Other Mixed background, please specify
- ☐ Other:

39.

38. Do you consider yourself to have a disability?*Mark only one oval.*☐

Yes

☐

No

40.

39. If yes, what is the nature of your disability?

41.

This doctoral project is also carrying out semi-structured interviews on a one-to-one basis. The interviews should last about 30 minutes and be on similar topics to the questions above (see information sheet attached for further details). Please write your contact details below if you would be willing to be contacted for an interview.

5. NVivo coding Structure report

26/06/2015 16:44

Node Structure

Critical mapping of mindfulness in Sussex

26/06/2015 16:44

Hierarchical Name

Node

Nodes

Nodes\\Memorable quotes

Nodes\\Not wanting to extrapolate from personal experience

Nodes\\Key Themes

Nodes\\Key Themes\\Choice

Nodes\\Key Themes\\Community

Nodes\\Key Themes\\Cost

Nodes\\Key Themes\\Cost-effectiveness

Nodes\\Key Themes\\Evidence

Nodes\\Key Themes\\Evidence\\Evidence for mindfulness

Nodes\\Key Themes\\Evidence\\Evidence for mindfulness\\Promotion to

Nodes\\Key Themes\\Evidence\\Evidence for nudge

Nodes\\Key Themes\\Evidence\\Measurement issues

Nodes\\Key Themes\\Evidence\\RCTs

Nodes\\Key Themes\\Evidence\\RCTs\\M4V specific

Nodes\\Key Themes\\Gender

Nodes\\Key Themes\\Implementation specific

Nodes\\Key Themes\\Inequalities

Nodes\\Key Themes\\Methodological issues

Nodes\\Key Themes\\Methodological issues\\Methodological

Nodes\\Key Themes\\Pain and mindfulness

Nodes\\Key Themes\\Pain and mindfulness\\More general comments

Nodes\\Key Themes\\Power

Nodes\\Key Themes\\Responsibility

Nodes\\Key Themes\\Self and subjectivity

Nodes\\Key Themes\\Stress

Nodes\\Key Themes\\Stress\\NHS-related stress

Nodes\\Key Themes\\The market

Nodes\\Key Themes\\Well-being agenda

Nodes\\Key Themes\\Well-being agenda\\Measurement of

Nodes\\Key Themes\\Work and productivity

Nodes\\M4V

Nodes\\M4V\\Attitudes on efficacy of mindfulness from WP2

Nodes\\M4V\\Attitudes on efficacy of mindfulness from WP2

Nodes\\M4V\\M4V participant nodes

Nodes\\M4V\\M4V participant nodes\\1. What been doing since the end

Nodes\\M4V\\M4V participant nodes\\1. What been doing since the end

Nodes\\M4V\\M4V participant nodes\\1. What been doing since the end

Nodes\\M4V\\M4V participant nodes\\1. What been doing since the end

Nodes\\M4V\\M4V participant nodes\\1. What been doing since the end

Nodes\\M4V\\M4V participant nodes\\1. What been doing since the end

Nodes\\M4V\\M4V participant nodes\\1. What been doing since the end

Nodes\\M4V\\M4V participant nodes\\1. What been doing since the end

Nodes\\M4V\\M4V participant nodes\\1. What been doing since the end

Nodes\\M4V\\M4V participant nodes\\10. If you could do it again, what

Nodes\\M4V\\M4V participant nodes\\11. Is there anything that you

Nodes\\M4V\\M4V participant nodes\\12. Advice to others in their

Nodes\\M4V\\M4V participant nodes\\2. Looking back over the 12

Nodes\\M4V\\M4V participant nodes\\3. Which part of the therapy did

Nodes\\M4V\\M4V participant nodes\\3. Which part of the therapy did

Nodes\\M4V\\M4V participant nodes\\3. Which part of the therapy did

Nodes\\M4V\\M4V participant nodes\\4. Which part of the therapy did

Nodes\\M4V\\M4V participant nodes\\5. Is there anything you still do

Nodes\\M4V\\M4V participant nodes\\5. Is there anything you still do

from the therapy\\CRT

Nodes\\M4V\\M4V participant nodes\\5. Is there anything you still do

Nodes\\M4V\\M4V participant nodes\\7. What was your experience of

Nodes\\M4V\\M4V participant nodes\\7. What was your experience of

Nodes\\M4V\\M4V participant nodes\\8. What for you is a measure of

Nodes\\M4V\\M4V participant nodes\8. What for you is a measure of

Nodes\\M4V\\M4V participant nodes\8. What for you is a measure of

Nodes\\M4V\\M4V participant nodes\9. Has the therapy helped with

any of this and how

Nodes\\M4V\\M4V participant nodes\9. Has the therapy helped with

Nodes\\M4V\\M4V participant nodes\Agency

Nodes\\M4V\\M4V participant nodes\Attendance

Nodes\\M4V\\M4V participant nodes\Body relationship

Nodes\\M4V\\M4V participant nodes\Body relationship\Mind and Body

Nodes\\M4V\\M4V participant nodes\Chair exercise

Nodes\\M4V\\M4V participant nodes\Choice

Nodes\\M4V\\M4V participant nodes\Control

Nodes\\M4V\\M4V participant nodes\Coping

Nodes\\M4V\\M4V participant nodes\Course resources

Nodes\\M4V\\M4V participant nodes\Course resources\Book -

Nodes\\M4V\\M4V participant nodes\Course resources\Literacy

Nodes\\M4V\\M4V participant nodes\Course resources\Summary

Nodes\\M4V\\M4V participant nodes\Course resources\Tape.MP3

Nodes\\M4V\\M4V participant nodes\Drug use and medication

Nodes\\M4V\\M4V participant nodes\Effort

Nodes\\M4V\\M4V participant nodes\Emotions

Nodes\\M4V\\M4V participant nodes\Emotions\Emotional Management

Nodes\\M4V\\M4V participant nodes\Follow-up

Nodes\\M4V\\M4V participant nodes\Hallucinations

Nodes\\M4V\\M4V participant nodes\Homework

Nodes\\M4V\\M4V participant nodes\How found out about trial

Nodes\\M4V\\M4V participant nodes\Internet

Nodes\\M4V\\M4V participant nodes\Learning that not alone in

Nodes\\M4V\\M4V participant nodes\Mind

Nodes\\M4V\\M4V participant nodes\Mind\Headspace Respite Pause

Nodes\\M4V\\M4V participant nodes\Mind\Memory

Nodes\\M4V\\M4V participant nodes\Mind\Own thought finding

Nodes\\M4V\\M4V participant nodes\Outcomes

Nodes\\M4V\\M4V participant nodes\Previous knowledge of

Nodes\\M4V\\M4V participant nodes\Recovery

Nodes\\M4V\\M4V participant nodes\Self-hood

Nodes\\M4V\\M4V participant nodes\Self-hood\Self Understanding

Nodes\\M4V\\M4V participant nodes\Self-hood\Self-worth

Nodes\\M4V\\M4V participant nodes\Therapist running the group

Nodes\\M4V\\M4V participant nodes\\Therapist running the group\\6.

Nodes\\M4V\\M4V participant nodes\\Trust

Nodes\\M4V\\M4V participant nodes\\Voices

Nodes\\M4V\\M4V participant nodes\\Voices\\Affinity with other voice

Nodes\\M4V\\M4V participant nodes\\Voices\\Overcoming Distressing

Nodes\\M4V\\M4V participant nodes\\Voices\\Own voice finding

Nodes\\M4V\\M4V participant nodes\\Voices\\Strategies for dealing with

Nodes\\M4V\\M4V participant nodes\\Voices\\Strategies for dealing with

Nodes\\M4V\\M4V participant nodes\\Voices\\Strategies for dealing with

Nodes\\M4V\\M4V participant nodes\\Voices\\Strategies for dealing with

Nodes\\M4V\\Specific models of care

Nodes\\M4V\\Specific models of care\\Medication

Nodes\\M4V\\Specific models of care\\Paul Chadwick model

Nodes\\M4V\\Ruth Chandler specific

Nodes\\M4V\\Ruth Chandler specific\\At time couldn't think'

Nodes\\M4V\\Ruth Chandler specific\\Bonding and sense of loss at

Nodes\\M4V\\Ruth Chandler specific\\Celebrating own difference

Nodes\\M4V\\Ruth Chandler specific\\Crisis management

Nodes\\M4V\\Ruth Chandler specific\\Effect lasting beyond the

Nodes\\M4V\\Ruth Chandler specific\\Getting to group therapeutic goal

Nodes\\M4V\\Ruth Chandler specific\\Identification

Nodes\\M4V\\Ruth Chandler specific\\Impact of literacy levels

Nodes\\M4V\\Ruth Chandler specific\\Is it just being in a group that

Nodes\\M4V\\Ruth Chandler specific\\Normalisation and safety without

Nodes\\M4V\\Ruth Chandler specific\\Size of group important

Nodes\\M4V\\Ruth Chandler specific\\Therapist able to get alongside

Nodes\\M4V\\Ruth Chandler specific\\Validation from peers as well as

Nodes\\M4V\\Ruth Chandler specific\\Want reduction of family and

Nodes\\Mental Health

Nodes\\Mental Health\\Anxiety

Nodes\\Mental Health\\Department of Health to address Standard One

Nodes\\Mental Health\\Depression

Nodes\\Mental Health\\Dual diagnosis

Nodes\\Mental Health\\Emotional health

Nodes\\Mental Health\\General mental health comments

Nodes\\Mental Health\\GP broader comments

Nodes\\Mental Health\\NICE

Nodes\\Mental Health\\Preventative

Nodes\\Mental Health\\Preventative\\Broader comments on preventative services or care

Nodes\\Mental Health\\Preventative\\Broader comments on

Nodes\\Mental Health\\Preventative\\Early Intervention

Nodes\\Mental Health\\Recovery

Nodes\\Mental Health\\Self-harm

Nodes\\Mental Health\\Sleep

Nodes\\Mental Health\\Therapy

Nodes\\Mental Health\\Therapy\\CAM comparison to mindfulness

Nodes\\Mental Health\\Therapy\\CAM comparison to

Nodes\\Mental Health\\Therapy\\CBT

Nodes\\Mental Health\\Therapy\\Establishment of Talking Therapies

Nodes\\Mental Health\\Therapy\\Homeopathy

Nodes\\Mindfulness

Nodes\\Mindfulness\\Ability to deal with difficulties in day to day life

Nodes\\Mindfulness\\Ability to deal with difficulties in day to day

Nodes\\Mindfulness\\Ability to deal with difficulties in day to day

Nodes\\Mindfulness\\Ability to deal with difficulties in day to day

Nodes\\Mindfulness\\Ability to deal with difficulties in day to day

Nodes\\Mindfulness\\Application for children

Nodes\\Mindfulness\\Application to older people

Nodes\\Mindfulness\\Application to policy

Nodes\\Mindfulness\\Application to policy\\Just one of a set of possible

Nodes\\Mindfulness\\Application to professional life

Nodes\\Mindfulness\\Application to professional life\\Application of

Nodes\\Mindfulness\\Application to professional life\\Application of mindfulness to professional life (repeat of below,

Nodes\\Mindfulness\\Application to professional life\\Clinical work

Nodes\\Mindfulness\\Application to professional life\\Clinical

Nodes\\Mindfulness\\Attendance

Nodes\\Mindfulness\\Attendance\\Importance of

Nodes\\Mindfulness\\Attendance\\Importance of\\Commitment

Nodes\\Mindfulness\\Attendance\\Want to attend in future

Nodes\\Mindfulness\\Attendance\\What effects attendance

Nodes\\Mindfulness\\Awareness and impressions of pre-course

Nodes\\Mindfulness\\Awareness and impressions of pre-
Nodes\\Mindfulness\\being more than doing
Nodes\\Mindfulness\\Books
Nodes\\Mindfulness\\Changes in lifestyle OR culture
Nodes\\Mindfulness\\Changes in lifestyle OR culture\\Life-style
Nodes\\Mindfulness\\Changes in lifestyle OR culture\\Slowing down
Nodes\\Mindfulness\\Compassion
Nodes\\Mindfulness\\Course structure
Nodes\\Mindfulness\\Course structure\\Delivery-manualisation
Nodes\\Mindfulness\\Course structure\\Length of course
Nodes\\Mindfulness\\Course structure\\Numbers
Nodes\\Mindfulness\\Courses adapted for other groups
Nodes\\Mindfulness\\Difference if GPs or clinicians have been on
Nodes\\Mindfulness\\East to West
Nodes\\Mindfulness\\East to West\\Acceptance of negativity and
Nodes\\Mindfulness\\East to West\\Religion or spirituality
Nodes\\Mindfulness\\East to West\\Religion or spirituality\\Religion
Nodes\\Mindfulness\\Evaluation
Nodes\\Mindfulness\\Evaluation\\Recommendations made for
Nodes\\Mindfulness\\External life events occurring at time of attending
Nodes\\Mindfulness\\External life events occurring at time of attending
Nodes\\Mindfulness\\External life events occurring at time of attending
Nodes\\Mindfulness\\External life events occurring at time of attending
Nodes\\Mindfulness\\External life events occurring at time of attending
Nodes\\Mindfulness\\Facilitation
Nodes\\Mindfulness\\Facilitation\\Embodiment
Nodes\\Mindfulness\\Facilitation\\Teaching experience
Nodes\\Mindfulness\\Facilitation\\Teaching experience\\Motivation for
Nodes\\Mindfulness\\Facilitation\\Teaching
Nodes\\Mindfulness\\Facilitation\\Teaching experience\\Qualification
Nodes\\Mindfulness\\Facilitation\\Teaching
Nodes\\Mindfulness\\Facilitation\\Teaching
Nodes\\Mindfulness\\Facilitation\\Teaching experience\\Qualification\\Training Centres UK
Nodes\\Mindfulness\\Facilitation\\Teaching experience\\Wider
Nodes\\Mindfulness\\Facilitation\\Teaching experience\\Wider
Nodes\\Mindfulness\\Follow-up support provided
Nodes\\Mindfulness\\Follow-up support provided\\Maintenance of

Nodes\\Mindfulness\\Follow-up support provided\\Maintenance of
Nodes\\Mindfulness\\Follow-up support provided\\Recommendations
Nodes\\Mindfulness\\Follow-up support provided\\Take-up of follow-up
Nodes\\Mindfulness\\Future research
Nodes\\Mindfulness\\Homework amount done
Nodes\\Mindfulness\\Homework amount done\\Specific exercised
Nodes\\Mindfulness\\Jon Kabat Zinn
Nodes\\Mindfulness\\MBSR
Nodes\\Mindfulness\\Meditation
Nodes\\Mindfulness\\Mind and body relationship
Nodes\\Mindfulness\\Mind and body relationship\\Body Scan
Nodes\\Mindfulness\\Mind and body relationship\\Embodiment
Nodes\\Mindfulness\\Mind and body relationship\\How mind and body
Nodes\\Mindfulness\\Mindfulness of breathing
Nodes\\Mindfulness\\Motivation for attending a mindfulness course
Nodes\\Mindfulness\\NHS provision
Nodes\\Mindfulness\\NHS provision\\Barriers to practice
Nodes\\Mindfulness\\NHS provision\\Dilution concerns
Nodes\\Mindfulness\\NHS provision\\Expectation management
Nodes\\Mindfulness\\NHS provision\\Referral pathways
Nodes\\Mindfulness\\NHS provision\\Referral pathways\\Factors when
Nodes\\Mindfulness\\NHS provision\\Roll-out issues
Nodes\\Mindfulness\\NHS provision\\Voucher option
Nodes\\Mindfulness\\No harm...
Nodes\\Mindfulness\\Non-specific factors
Nodes\\Mindfulness\\Popularity
Nodes\\Mindfulness\\Popularity\\Government take-up or awareness
Nodes\\Mindfulness\\Popularity\\GP current attitudes or awareness
Nodes\\Mindfulness\\Popularity\\How attribute popularity
Nodes\\Mindfulness\\Popularity\\Public attitudes towards
Nodes\\Mindfulness\\Relationship with other course participants
Nodes\\Mindfulness\\Relationship with other course
Nodes\\Mindfulness\\Relaxation
Nodes\\Mindfulness\\Self help
Nodes\\Mindfulness\\Strong memories
Nodes\\Mindfulness\\Sussex specific comments
Nodes\\Mindfulness\\Sussex specific comments\\Communication within
Nodes\\Mindfulness\\Sussex specific comments\\Comparison to other
Nodes\\Mindfulness\\Sussex specific comments\\Employer or

Nodes\\Mindfulness\\Sussex specific comments\\Employer or
 Nodes\\Mindfulness\\Sussex specific comments\\Funding
 Nodes\\Mindfulness\\Sussex specific comments\\Sussex Mindfulness
 Nodes\\Mindfulness\\Sussex specific comments\\Sussex Mindfulness
 Nodes\\Mindfulness\\Sussex specific comments\\Training programme
 Nodes\\Mindfulness\\Technology
 Nodes\\Mindfulness\\Technology\\Online mindfulness provision
 Nodes\\Mindfulness\\Technology\\Use of for mindfulness compared to
 Nodes\\Mindfulness\\Technology\\Use of for mindfulness compared to
 face-to-face\\Apps
 Nodes\\Mindfulness\\When might Not be useful
 Nodes\\Mindfulness\\Which provider

Nodes\\Nudge

Nodes\\Nudge\\Agenda and mindfulness
 Nodes\\Nudge\\Attitudes towards
 Nodes\\Nudge\\Current nudges
 Nodes\\Nudge\\Framing of mindfulness
 Nodes\\Nudge\\Previous awareness of
 Nodes\\Nudge\\Recommendations for follow-up support
 Nodes\\Nudge\\Recommendations for promotion
 Nodes\\Nudge\\Whose responsibility for behaviour change

Nodes\\Participants\\Online survey data free-text

Nodes\\Participants\\Online survey data free-text\\10. Has being on the
 Nodes\\Participants\\Online survey data free-text\\11. Any other
 Nodes\\Participants\\Online survey data free-text\\14. How explain or
 Nodes\\Participants\\Online survey data free-text\\22. Factors in
 Nodes\\Participants\\Online survey data free-text\\36. Any further
 Nodes\\Participants\\Online survey data free-text\\9. Course effected
 relationship with body

Nodes\\Participants\\WP1

Nodes\\Participants\\WP1\\Beth
 Nodes\\Participants\\WP1\\Clare
 Nodes\\Participants\\WP1\\Debs
 Nodes\\Participants\\WP1\\Harry
 Nodes\\Participants\\WP1\\Lauren
 Nodes\\Participants\\WP1\\Lex
 Nodes\\Participants\\WP1\\Toby

Nodes\\Participants\\WP1\\Tony

Nodes\\Participants\\WP2

Nodes\\Participants\\WP2\\Daniel

Nodes\\Participants\\WP2\\Helen

Nodes\\Participants\\WP2\\Hilary

Nodes\\Participants\\WP2\\Mark

Nodes\\Participants\\WP2\\Teresa

Nodes\\Participants\\WP2\\Yvonne

Nodes\\Participants\\WP3

Nodes\\Participants\\WP3\\Adam

Nodes\\Participants\\WP3\\Becca

Nodes\\Participants\\WP3\\Brandan

Nodes\\Participants\\WP3\\Eleanor

Nodes\\Participants\\WP3\\Emma

Nodes\\Participants\\WP3\\Janet

Nodes\\Participants\\WP3\\Jim

Nodes\\Participants\\WP3\\Matthew

Nodes\\Participants\\WP3\\Neil

Nodes\\Participants\\WP3\\Phillip

Nodes\\Participants\\WP3\\Stef

Nodes\\Participants\\WP3\\Steve

Nodes\\Participants\\WP3\\Tilly

Nodes\\Participants\\WP4

Nodes\\Participants\\WP4\\Chris

Nodes\\Participants\\WP4\\Izzie

Nodes\\Participants\\WP4\\John

Nodes\\Participants\\WP4\\Kath

Nodes\\Participants\\WP4\\Margaret

Nodes\\Participants\\WP4\\Peter

Nodes\\Participants\\WP4\\Rachel

Nodes\\Participants\\WP4\\Simon

Nodes\\Participants\\WP4\\Sue

Relationship

Relationships

Relationships\\2. Looking back over the 12 sessions of the therapy,

Relationships\\3. Which part of the therapy did you find the most

Relationships\\Attendance (Associated) Relationship with other course

Relationships\\Attitudes on efficacy of mindfulness from WP2

Relationships\\CBT (is related to) East to West

Relationships\\Choice (Associated) Just one of a set of possible

Relationships\\Choice (Associated) What effects attendance

Relationships\\Choice (is married to) Chair exercise

Relationships\\Communication within the Trust (is married to)

Relationships\\Community (Associated) Recovery

Relationships\\Community (Associated) Technology

Relationships\\Control (Associated) Voices

Relationships\\Cost-effectiveness (Associated) Follow-up support

Relationships\\Cost-effectiveness (Associated) Popularity

Relationships\\Depression (Associated) Motivation for attending a

Relationships\\Depression (Associated) Pre-course

Relationships\\Difference if GPs or clinicians have been on

Relationships\\Difference if GPs or clinicians have been on

Relationships\\Effort (Associated) Attendance

Relationships\\Effort (Associated) Headspace Respite Pause

Relationships\\Embodiment (is married to) Dilution concerns

Relationships\\Evidence (is married to) Application to policy

Relationships\\External life events occurring at time of attending

Relationships\\Facilitation (Associated) Relationship with other course

Relationships\\Facilitation (Associated) When might Not be useful

Relationships\\Facilitation (is married to) Embodiment

Relationships\\Homework amount done (Associated) Attendance

Relationships\\Impact of literacy levels (Associated) Follow-up

Relationships\\Implementation specific (Associated) East to West

Relationships\\Implementation specific (relies upon) Evidence

Relationships\\Importance of peers (is married to) Recovery

Relationships\\Learning that not alone in experience (Associated) 7.

Relationships\\Learning that not alone in experience (Contributes to)

Relationships\\Measurement of (Associated) Evaluation

Relationships\\Meditation (Contributes to) Previously on the

Relationships\\More general comments (is married to) Mind and body

Relationships\\NHS provision (Associated) Implementation specific

Relationships\\NICE (Associated) NHS provision

Relationships\\NICE (is married to) Evidence

Relationships\\Non-specific factors (Associated)	Online mindfulness
Relationships\\Non-specific factors (is related to)	Attendance
Relationships\\Non-specific factors (is related to)	Relationship with other course participants
Relationships\\Online mindfulness provision (Associated)	Relationship
Relationships\\Outcomes (Associated)	1. What been doing since the
Relationships\\Outcomes (Associated)	8. What for you is a measure of
Relationships\\Own thought finding (Associated)	Self-hood
Relationships\\Pain and mindfulness (is married to)	Mind and body
Relationships\\Popularity (is related to)	NICE
Relationships\\Practicality (Associated)	Self-empowering
Relationships\\Previously on the participants cultural or professional	
Relationships\\Previously on the participants cultural or professional	
Relationships\\Professionalisation (Associated)	Evidence for
Relationships\\Promotion to GPs (Associated)	GP current attitudes or
Relationships\\Relationship with other course participants (Associated)	
Relationships\\Relationships with thoughts (Associated)	Mind and
Relationships\\Relationships with thoughts (is married to)	being more
Relationships\\Religion or spirituality (Associated)	Dilution concerns
Relationships\\Roll-out issues (Associated)	Cost
Relationships\\Roll-out issues (Associated)	Qualification
Relationships\\Self and subjectivity (Associated)	Relationships with
Relationships\\Self Understanding (is married to)	Coping
Relationships\\Stress (Associated)	Inequalities
Relationships\\Stress (is married to)	Inequalities
Relationships\\Take-up of follow-up support (is related to)	Maintenance
Relationships\\Technology (Associated)	Maintenance of practice post-
Relationships\\Use of for mindfulness compared to face-to-face	
Relationships\\Use of for mindfulness compared to face-to-face (is	
Relationships\\Whose responsibility for behaviour change (is married	
Relationships\\Work and productivity (Associated)	Well-being agenda

6. Framework analysis table example

1. Group Dynamics

Normalising/validating	<ul style="list-style-type: none"> - 1g. Not scary or intimidating, comfortable. Normalising and validating, learning from peers as well as the therapist (<i>'all seemed to be similar people to me'</i>). Bonding and a sense of loss when it ended. - 1d. Helpful going around the group and identifying different strategies (hearing others) - 1h. Nice because can work with others/listen to their experiences. - 1a. The other people in the group rather than the therapy. Had stronger memories of experience of transcendental meditation. - 1c. Laminated card used as tool in the group: <i>'don't put yourself down'</i>. Social side as the strongest memory. - 1g. Normalising and validating of unusual experiences - 1b. Listening to stories of other people in group was a common strongest memory.
Change to feelings about being in a group beforehand	<ul style="list-style-type: none"> - 1h. Did not want to go because thought would be judged. Was not as expected. - 1a. Normally felt intimidated but didn't. - 1f. Nervous and hadn't liked being in groups. - 1d. Couldn't be put on the spot before but now talking in front of the group. - 1h. Did not want to go because thought would be judged. Was not as expected. - 1e. Nervous, didn't know if would speak but then spoke first in the MBCT course - surprise at self (link to self-confidence) - 1g. Nervous about being in a group (size of group as important), had been in a Hearing Voices group before but not

	<p>enjoyed it – compared favorably to the MBCT course (important for 'is it just being in a group' effects)</p> <ul style="list-style-type: none"> - 1d. Previous feelings of panic and anxiety overcome. - 1d. Boost in social skills from the therapy (coped with 5-11 group numbers) - 1f. Group made social connections, course speaks to people. More social resources/capital. Remembers the social interaction and bonding. The group is still meeting 6 months later but in a pub where he cannot go. - 1a. Normally felt intimidated but didn't (but also needed to talk it through with a friend first). expressed mixed feeling about group - 1f. Nervous and hadn't previously liked being in groups.
Connections made between group members	<ul style="list-style-type: none"> - 1f. Group made social connections, course speaks to people. More social resources/capital. Remembers the social interaction and bonding. The group is still meeting 6 months later but in a pub where he cannot go. - 1a. Sense of alienation from others in the group who hadn't had this experience (link to group)
Other impacts of group experience	<ul style="list-style-type: none"> - 1h. Seeing how it was for others helped (link to finding voice). Sense of shared learning ('actually talked to people'). Did stay in touch with some of the group for a while. Longevity (unusual). - 1a. The other people in the group rather than the therapy. - 1e. Positive experience - 1c. Importance of having people listen. Overcoming paranoia when not the centre of attention - 1f. Feels had choice to speak in the group - 1g. Must show success of group because looked forward to going every week. 'When you're there it sort of

	<p>lifts you'.</p> <p>Sadness at ending.</p> <ul style="list-style-type: none"> - 1g. Learnt a lot (and from peers). Link to trust - established early in the process, made up their mind in the very first session. - 1c. Helps a lot to be in a room with sympathetic people and hear their stories. - 1a. Got to see other people and the way they interact and how they lead their lives. - 1b. Highly important relating to group safety ('kept everyone in line'). (1b filled this space with 'dress' linked to self-worth/self-perception)
Therapist running the group	<ul style="list-style-type: none"> - 1d. Qualities: calm, not pushy, concise, clear and measured. - 1e. Clarity, plain speech (can't read). Perceived as authoritative and able to get alongside experience. No pressure and relaxed. Embodied. - 1c. Knew therapist beforehand which was important - 1a. Relaxation technique mentioned, not strong memories of the therapist.)The only person who was unbothered about who was running the course). - 1b. Highly important relating to group safety ('kept everyone in line'). 1b filled this space with 'dress' linked to self worth/self-perception - 1f. Important

	- 1g. Learnt a lot (and from peers). Link to trust - established early in the process, made up their mind in the very first session.
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2. Coping

Calms and focuses: <i>platform between social recovery and coping</i>	<ul style="list-style-type: none"> - 1g. Calms and keeps focused. - 1g. Relaxes and calms enough to get through what need to do, but about effort and focus on the body - 1c used mindfulness to cope while in house alone - 1e uses body scan to relax on bed - 1h helps to manage and keep things in perspective as platform for choice
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3. Recovery

a. Personal Recovery	Supporting Quotes
Calming/focus <i>(platform between coping and recovery)</i>	<ul style="list-style-type: none"> - 1g. Calms and keeps focused. - 1g. Choice; '<i>I don't need to be silly</i>'. More focus: calming and energy. '<i>I'm not in danger</i>' - link to self-determination. Does think about hurting herself (beachy head) but thinks of family and works against command hallucinations. (link to positive group dynamic to, move to choice) - 1g. notices difference between relaxation and mindfulness - 1b. Calms down with the tape; sense of reduction of intensity/overwhelmingness of the voices (list helpful

	again)
Hope for the future	<ul style="list-style-type: none"> - 1b. Understanding hope for future <i>is</i> possible. Knowing there is a solution comes from both being in a group and the practice - 1c. Not in place but wants it. Importance of not feeling alone. - aspiring knowing that it is possible to detach from difficult emotions and that the difficult emotions will pass helps * What for you is a measure of success in a therapy? - 1b. General sense of well-being. Knowing other people experience same thing and knowing that there <i>is</i> a solution. - 1d. Feeling better...striving recognised; '<i>gotta get there</i>'. Chair exercise - 1d. Exercise has brought awareness and hope ('even when unwell...might just be blip'). A strong thing extra to the group. - 1e. Course made her realise you can get there you can get better - 1a. Wants to learn as much about own illness, the more I learn the more I know. - 1c. Wants to give back help given by MH professionals. Wants to try to get off benefits - 1g. Celebrating own difference, tension clearly ongoing, course helped affirms

b. Social Recovery	Supporting Quotes
Meaningful social interaction	<ul style="list-style-type: none"> - 1f. Socially isolated through mental health (not being achieved) - 1e. Puppy sitting son's puppy (link to Recovery). Her son is the one she goes to for support. Difference in support- seeking since attending the course. - 1g. Want reduction personal distress and causing her family distress. Lives with parents, got family/friends and previously employed. Family plays positive role. - 1f. Got family living really close. Motivating factor in going on the course. - 1a. To get it, to come away with a tool. (identified the course for the trial and error that it is!). Quite undefined...but ability to meet with strangers is a measure of success. - 1d. Family had been noticing improvement. - 1a. Nice knowing not alone in group.

	<p>repercussions)</p> <ul style="list-style-type: none"> - 1b. Not to be swayed by others (link to self-worth and assertiveness). Stuck to exercises & list of what to do with voices (seemed like she thought I was checking up on her, bit of a script. Ruth read this into this too without my prompt). - 1c. Not putting self down or feeling to blame (link to CBT elements of book) - 1c. Ok to be miserable, does not mean am weak (quite gendered) regaining sense of humour. Laugh more these days. Self-compassion; '<i>try not to put myself down</i>' (link to coping). Looking for good things in life (different for different people). Guilt and low self-esteem; '<i>used to take drugs</i>'.
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4. Control/choice/agency

Control	<ul style="list-style-type: none"> - 1h. Helps with situations that otherwise might go out of control. - 1h. Helps with major crises, going into hospital (link to control and outcomes) - 1e. Not having to use children for respite (control and independence and measure of success). Didn't have to let the voices be in charge. - 1d. CBT helped with voices not always in control. Mindfulness felt like loss of control.
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<p>- Less voice hearing/following of voice commands (<i>Have as separate category for now but present as point of discussion</i>)</p>	<p>- 1e. Less voice hearing and more coping strategies (link to coping) instead of following the voice commands (i.e. self-harm: before the course had tried to stop for her kids but the voices had overcome her).</p> <p>- 1g. Takes self off when voices get too much to listen to MP3.</p> <p>- 1f. Helped for a while but now back to square one.</p> <p>- 1d. Different way of thinking about the voices.</p> <p>- 1b. Walking into the room had heard terrible voices about herself and now knows there is a solution.</p> <p>- 1a. Voices are pushed away while doing the body scan.</p> <p>- 1e. Less voice hearing and more coping strategies (link to coping) instead of following the voice commands (i.e. self-harm. Before the course had tried to stop for her kids but the voices had overcome her). Voices not in charge. Had been having command hallucinations telling her to cut herself, 'at time couldn't think' (link to voices). <i>'At one time I just thought I was crazy'.</i></p> <p>- 1c. Awareness that would like to see a therapist in the future; sense that would like to dig further in a more focused therapy (unusual in this respect?) - (running of course)</p> <p>- 1g. Would want therapist (dependent on availability of support in actuality though...)</p> <p>- 1f. Felt had got support and that this was important.</p> <p>- 1f. Quite depressed, still using the MP3 quite often (link to course resources). Says other people should go on the</p>
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<p>- Learning about condition/Self-understanding</p>	<p>course. Would do it again even though was at lowest ebb.</p> <ul style="list-style-type: none"> - 1a. Transcendental meditation for a deeper relaxation to cope with voices - 1g. Learnt something new about condition and how to handle (link to coping). Able to say 'I'm not in danger'. Celebrating own difference, tension clearly ongoing, course helped affirm self-worth but struggle clearly ongoing. - 1e. Self understanding (check where this might have come from) - 1b. Understanding that its an illness and you can come out the other side (move to hope for the future).More learn more can cope. - 1b. Keeps a list of what to do when the voices start attacking.
<p>Choice</p>	<ul style="list-style-type: none"> - 1e. Dealing with anger, removal from situation with annoying woman in her accommodation (had to leave and stay with her son before). - 1f. Feels had choice to speak in the group - 1g. Takes self off to listen to the tape when she find company difficult (link to choice and control) - 1d. Listening to music as strategy and hearing other's strategies from the group. Had been using them since the end of the course (goes for a walk with dog/gym/fills time). - 1g. Choice; '<i>I don't need to be silly</i>'. More focus: calming and energy. '<i>I'm not in danger</i>' - link to self-determination. <p><i>Does think about hurting herself (beachy head) but thinks of family and works against command</i></p>

<p>- Choice to let go</p> <p>- Crisis prevention (<i>note as example</i>):</p> <p>- Chair exercise</p>	<p>hallucinations (link to positive group dynamic). Had self-worth but struggle clearly ongoing.</p> <p>- 1h. can bring mind down to point where can choose to focus on not having a major crisis</p> <p>- 1c. Importance of letting go, of seeing the world as an enemy and fighting way through the day. (coping linked to letting go - move to interpersonal theme. World constructed as a person)</p> <p>- 1e. not brewing on anger with difficult woman</p> <p>- 1d. 'I gotta get there' thoughts, now feels is kind of there, less need to strive.</p> <p>- 1h. Helps with major crises, going into hospital (link to control and outcomes) - coping</p> <p>- 1h. Helps with situations that otherwise might go out of control. - coping and social recovery</p> <p>- 1h. Crisis prevention; brings mind back to a manageable place.</p> <p>- 1e. Found own voice and normalisation over fear of sectioning and hospitalisation (safety without treatment repercussions).</p> <p>- 1h. The breathing exercise, and using the chair for different chair/different thoughts (link to choice)</p> <p>- 1g. Spontaneous answer. Having choice over which chair important</p> <p>- 1d. Choice to sit in the negative chair and be unwell.</p> <p>- 1e. Could choose which chair and I went straight away to the positive chair.</p>
<p>Relationship with Voices:</p>	<p>- 1e. Less voice hearing and more coping strategies (link to coping) instead of following the voice commands (i.e.</p>

	<p>self-harm. Before the course had tried to stop for her kids but the voices had overcome her).</p> <ul style="list-style-type: none"> - 1e. Voices not in charge. Had been having command hallucinations telling her to kill woman - 1a. TM 'pushes the voices away' (same as the woman on the bus but 1a. needs TM to do this). 'Pushing' language significant; not mindful. - 1c. Pick fights better - 1b. The things they say are very cruel
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5. Interpersonal relationships

<p>Self-worth/ understanding <i>(owning negative thoughts helps with this)</i></p>	<ul style="list-style-type: none"> - 1e. Self-worth, self-assertion, confidence, (link to strongest memory) - 1b. not being swayed by other people - 1e. Not having to use children for respite (control and independence). - 1g. Ability to deal with nerve-wracking situations (use on bus). Coping - 1b. Recognising own negative thoughts as barrier to self worth - 1e. Self-understanding through group.
<p>Self/other <i>Park for now</i></p>	<ul style="list-style-type: none"> - 1a. Relation to others- link to specific quote about feeling alienated and connected to the group. (Dichotomy between feelings of alienation <i>and</i> openness to difference, a negotiation of difference between and self and other. This becomes an affirmation and confidence about difference (psychotic experiences being hard to hold) some paranoia about others in group as all on drugs. - 1g. Won't say exercises out loud on bus '<i>otherwise people will think I'm a nutter</i>'. Self-harm and neighbour.

Appreciation of difference	<p>- 1a. Thoughts of others in the group relying on drugs (not prescription). Appreciation of <i>difference</i> in other people and</p> <p>their and others stories, knowing that not alone in his experience. Contradictory message though of people going</p> <p>through the <i>same</i> thing as him. Not a constant message given). Not really feels part of it; 'someone else talking so I</p> <p>tend to switch off', and alienated in the group.</p>
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6. Variation about which bits of the course were helpful

Effort	- 1g. Cannot just sit there and say 'doesn't work for me', need to put in effort.
Attendance	<p>- 1h. If had gone to everyone thought would've made a massive difference. If offered again then would have put more effort</p> <p>in (link to effort)</p> <p>- 1g. Did all of the groups; committed to it ('even when having a bad week..' - committed to it). Getting to the group as a</p> <p>therapeutic goal in itself.</p> <p>- 1d. Do the whole 12 weeks; commitment important (reported positive effects having done this, of finding and holding on to</p> <p>hope - tricky when something's enduring)</p> <p>- 1g. Did all of the groups; committed to it ('even when having a bad week..' - committed to it). Getting to the group as a</p>

	therapeutic goal in itself.
Depth	<ul style="list-style-type: none"> - 1a. Would have like another course running alongside and option to go deeper if had wanted to (link to improvement). Need for differentiation as in other courses. Wanted deeper therapy (transcendental meditation course), was not intense enough for an intelligent man? Found it a bit shallow and not enough homework given. - 1f. needed support to access course materials
Length of effect	<ul style="list-style-type: none"> - 1a. Had done transcendental meditation in past, wanted more of it (has longer effects). Only participant with previous experience of meditation - 1g. Continues to benefit in reducing suicidal thoughts. - 1b. About 15 minutes. - 1a. Only lasts as long as doing the exercise.
Degree to which helps	<ul style="list-style-type: none"> - 1e. Helps a bit (medium) - 1a. Exercises work in the moment but stop when stop the exercise. Getting that initial respite is hard. - 1f. Felt had got support and that this was important.
Access issues	<ul style="list-style-type: none"> - 1h. Would use internet (but was trying to get end the interview) - 1a. Not on the internet but would do it online if had it, and do follow-up this way - 1b. Not internet literate. Notion of list coming back, containing way of managing anxiety
If you could do it again, what would you change (if anything) about the	<ul style="list-style-type: none"> - 1c. Too much paperwork - 1g. Only 12 weeks long, that it cannot be available all the time. - 1a. Wanted deeper therapy (transcendental meditation course), was not intense enough for an intelligent man?

therapy?	<p>Found it a bit shallow and not enough homework given. Was critical about the course but this was leading on to other activities,</p> <p>does Tai Chi in the community. Also said would find 1 on 1 therapy helpful. Would run a course in TM and relaxation techniques on the side. Wanted more age-specific services, did not feel that there were the services for people his age over the 16-25 bracket.</p> <ul style="list-style-type: none"> - 1h. Age-matching; would have like to've done it with other young people. - 1a. Was critical about the course but this was leading on to other activities, does Tai Chi in the community. <p>Also said</p> <p>would find 1-on-1 therapy helpful. Would run a course in TM and relaxation techniques on the side. Wanted more age-specific services, did not feel that there were the services for people his age over the 16-25 bracket.</p> <ul style="list-style-type: none"> - 1g. Would want therapist (dependent on availability of support in actuality though...) - 1c. Awareness that would like to see a therapist in the future; sense that would like to dig further in a more focused therapy (unusual in this respect?)
Homework	<ul style="list-style-type: none"> - 1g. Homework was easy enough
Follow-up support	<ul style="list-style-type: none"> - 1b. Evaluation/exit interview was seen as follow-up support (cannot use other options as data as they were given by me in

	<p>the interview) (running of the course)</p> <ul style="list-style-type: none"> - 1e. Continues to be supported from staff in residential home reading book to her to manage difficult situations and practice exercises - 1f. Has follow up support from ***** -1a. One-on-one therapy would have been helpful.
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7. Mind/Body Relationship

Memorable techniques	
Breathing exercise	<ul style="list-style-type: none"> - 1h. The breathing exercise is the one she tends to use, and using the chair for different chair/different thoughts - 1d. Felt anxious focusing on breath because of the panic attacks.
Mind	<ul style="list-style-type: none"> - 1g. Try and clear mind; 'start with an empty mind' with voices (link to effort and relaxation), voices are '<i>still there but put to the back a little bit</i>' for that 10 minutes of peace. The fact that it can last beyond the exercise is significant. - 1c. Interested in the CBT-side, the evidence for certain thoughts. - 1d. CBT most helpful bit.
Body scan	<ul style="list-style-type: none"> - 1g. Energy rush, does the exercise on the bus to get through the journey home - focuses on feelings in her feet (strongest memory for her)

<p>Book - <i>Overcoming Distressing Voices</i></p> <p>MP3</p>	<ul style="list-style-type: none"> - 1d. Does the exercises lying down on her bed; 'like going to sleep'. Focus on breath wasn't helpful as have panic attacks, felt a bit more tuned into it but felt was going to die. - 1h. Didn't like the body scan but it does take attention from other things. Notices aches/pains and physical discomfort (not that unusual) - link to thought management (links to ageing here) - 1e. Usually lie down on the bed to do the exercise. - 1c. Wants to re-read. Books has been great follow-up. - 1g. Still reads it - 1e. Likes: not alone in experience - 1g. Really helpful: identification ('could've been me writing that book'). Really engaged with the experience (does speak to people having that experience). - 1c. Useful as addition, noted that written by therapists - 1e. Likes: not alone in experience (check where this might have come from) - 1g. Really helpful: identification ('could've been me writing that book'). Really engaged with the experience (does speak to people having that experience) - 1a. Got the book and uses it - 1c. Remembers the name of the book (but taken 'low self-esteem' from it - chase up this meaning) - 1e. Is read the book by staff where she lives and finds very useful (literacy issues).
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<p>Receptivity to techniques</p>	<ul style="list-style-type: none"> - 1a. Mentions was given book by research assistant and that it was useful. - 1g. Trying to keep up with MP3 player, tops up with it when has a bad episode. - 1h. Not really used much but still uses the recordings. Stuck in mind though, and using both together helped (different to other interviews) - 1g. Still using: agency in use of tape (link to agency). Tries to use even if only once a month. - 1b. Calms down with the tape; sense of reduction of intensity/overwhelmingness of the voices (list helpful again) - 1d. Listening to music as strategy and hearing other's strategies from the group. Had been using them since the end of the course (goes for a walk with dog/gym/fills time). - 1f. Quite depressed, still using the MP3 quite often (link to course resources). Says other people should go on the course. Would do the course again even though was at lowest ebb. - 1c. Doesn't listen to anymore. First time used felt like using ear-muffs as a strategy against the voices. - 1e. Listens to when the voices come. - 1c. Receptive to it as a practical technique - evidence (quote about 'challenging'). Got what they were trying to teach. CBT (compared to mindfulness) looks at the evidence for causes of distress about self (looks a bit but not why a person did
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	<p>x, y, z...MBCT is not trying to do this though...).</p> <ul style="list-style-type: none"> - 1c. Using the attitude rather than the practice: Anxiety: '<i>can be aware of it...knowing it will pass</i>' (a year and a half after attending the course). (link to memory which can help). '<i>Feeling awful now but will go...this too will pass</i>'. Mindfulness not dealing with the <i>causes</i> of distress. - 1a. Receptive to meditation but wanted at a deeper level.
Headspace/Letting go	<ul style="list-style-type: none"> - 1e. Territory for respite/rest...thinking twice. Accepting and reacting. (Value of anything to get a moment of choice as a voice-hearer, getting that space in which a voice couldn't happen. Mindfulness works in this way, when the person is going into the body the voices have not gone away but are gently noticed, giving this space for self-assertion, even if you can only get a little bit of space. Data suggesting quite a lot of this re: people using the techniques to be able to get this space (on the bus, working with a given situation). - 1c. Use of headphones in itself a respite from voices - 1g. voices not so prominent in mind gets a little peace - 1c. Importance of letting go, of seeing the world as an enemy and fighting way through the day. (coping linked to letting go) <p>What for you is a measure of success in a therapy?</p>

	<ul style="list-style-type: none"> - 1c. Discerning what to be able to detach from/let go even if gives you distress. (mindfulness about letting go of goals but goals are good for you too!) social recovery too. -1e. Not brewing on difficult feelings towards neighbour. A lot of anger had been effecting her life..not completely let it go but detached self from it. -1c. Trying to deal with anger better and let go of frustration with parents.
<p>Relationship with body</p> <p>Which parts of course helpful (CBT/Mindfulness) (<i>Very important measure of ambivalence towards the body</i>)</p>	<ul style="list-style-type: none"> - 1b. Has changed but can't really describe it - 1e. Remembered feet and feelings of being relaxed and relieved feeling light after body scan, not so weighty. - 1f. 'Numb but it's a good numb' - 1a. Does Tai Chi - balance of energy and getting out of the mind. - 1d. Feel a bit more tuned into his body, now realise that when the panic attack breathing starts, that not going to die..and can leave the house/other strategies. - 1c. Using the attitude rather than the practice: Anxiety: '<i>can be aware of it..knowing it will pass</i>' (a year and a half after attending the course). (link to memory which can help). '<i>Feeling awful now but will go..this too will pass</i>'. Mindfulness not dealing with the <i>causes</i> of distress. - 1d. Different ways of coping with them. Found the CBT rather than the mindfulness helpful. Panic attacks given

	<p>as a</p> <p>reason; body not a place to dwell in, best to lie on the ground (link to CBT over Mindfulness, and relationship with body)</p> <ul style="list-style-type: none"> - 1d. Does the exercises lying down on her bed; 'like going to sleep'. Focus on breath wasn't helpful as have panic attacks, <p>felt a bit more tuned into it but felt was going to die.</p> <ul style="list-style-type: none"> - 1f. Had support with reading the materials - 1h. Didn't like the body scan but it does take attention from other things. Notices aches/pains and physical discomfort (not <p>that unusual) - link to thought management</p> <ul style="list-style-type: none"> - 1c. Doesn't practice but the ideas have given him ways of coping, remembers as helpful - perhaps will do exercises in the <p>future; used mindfulness to cope in a difficult situation helped him sleep</p>
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8. What is memorable and what do people still do?

Length of effect	<ul style="list-style-type: none"> - 1g. Try and clear mind; '<i>start with an empty mind</i>' with voices (link to effort and relaxation). The fact that it can last beyond <p>the exercise is significant.</p> <ul style="list-style-type: none"> - 1h. Bit of an effect afterwards. If you put effort in it will come back to you. Still listens to recordings and have got on a <p>phone.</p>
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	<ul style="list-style-type: none"> - 1b. Voices returned 15 minutes after the end of the exercise. Helps with sleep and family ('back to the way things were'). - 1a. Exercises work in the moment but stop when stop the exercise. Getting that initial respite is hard - 1c. Took away from the group the hope that will practice in the future. - 1a. Still does the meditation techniques 3 x's a day (participant doing it the most?). Only indoors. Likes it but wants it to have lasting effect. - 1g. Would want therapist (dependent on availability of support in actuality though...)
Degree to which helps over time	<ul style="list-style-type: none"> - 1e. Helps a bit (medium) - 1f. Still doing even though at lowest point at time of interview - 1e. Had/has staff support with reading the course book (and reminders to listen to the tape?). Role of this in reinforcement of learning from the course (link to course resources) - 1f. Quite depressed, still using the MP3 quite often (link to course resources).
Shared learning with group members	<ul style="list-style-type: none"> - 1h. Seeing how it was for others helped (link to finding voice). Sense of shared learning ('actually talked to people'). Did stay in touch with some of the group for a while. Longevity (unusual). - 1f. Wanted to stay in touch, others still meet but in the pub where he cannot go. - 1a. Thoughts of others in the group relying on drugs (not prescription drugs). Appreciation of <i>difference</i> in other people and their and others stories, knowing that not alone in his experience. Contradictory message though of people going

	<p>through the <i>same</i> thing as him. Not a constant message given). Not really feels part of it; '<i>someone else talking so I</i></p> <p><i>tend to switch off</i>', and alienated in the group.</p> <ul style="list-style-type: none"> - 1h. Seeing how it was for others helped (link to finding voice). Sense of shared learning ('<i>actually talked to people</i>'). Did stay in touch with some of the group for a while. Longevity (unusual). - 1b. Really helpful (talked about even before question was asked). Recognition of the right to speak was important (link to finding own voice, assertiveness and reduction in voice-hearing and anxiety) - 1e. Nervous, didn't know if would speak but then spoke first in the MBCT course - surprise at self (link to self-confidence) - 1g. Validating and normalising to hear unusual experiences of others.
Follow-up support	<ul style="list-style-type: none"> - 1b. Evaluation/exit interview was seen as follow-up support (cannot use other options as data as they were given by me in the interview) - 1e. As above. Regretted that was having a bad period at that time.

7. Initial topic guide for interviews with mindfulness teachers (WP4)¹³⁹:

Date:

Start time of interview:

Finish time:

Male/Female (circle one)

- Why did you become a teacher of mindfulness?
- How long have you been a teacher/facilitator?
- Could you tell me a bit about your journey as a teacher and wider involvement in mindfulness in terms of:
 - Personal development, relationship with your body and ability to cope with difficulties..
 - Wider involvement in terms of other organisations/consultation/report/book writing?
- What kind of follow-up support do you offer after your courses?
- What are the take-up rates like for this support and do you think it is meeting people's needs?
- Is there any other support which you think might/could be helpful?
 - *Space booked in a community centre on a regular basis (as arranged between the participant members) with no member of staff.*
 - *Space booked in a community centre on a regular basis (as arranged between the participant members) with a facilitator (if so who would you prefer this facilitator to be?)*
 - *A private online website/forum (using a password) where course members could log on and be in touch with each other.*
 - *An open online website/forum (where members of the public could join in with discussions/join in) where course members could log on and be in touch with each other.*
 - *Communication with other participants on an ad hoc informal basis via email*
 - *Communication via email between a member of staff/course leader and individual participants?*
- From your experience so far, what do you think affects sign-up rates and attendance on mindfulness courses?
- How do you think the experience of using an online course might compare to attending a course in person?

139 This was the original list of questions that was then adapted following each interview.

- How do you think mindfulness compare to other complementary and alternative (CAM) health courses?
 - Do you see an awareness of mindfulness or it being popular at the moment with members of any of these (or other) groups: public/policy makers/GPs/clinicians?
 - If so how would you explain this popularity?
 - Do you think it makes any difference to the service they provide if clinicians/GPs/other NHS and voluntary group staff have been on a mindfulness course themselves?
 - My study is looking at communication of health messages to different sections of the population and the spreading of evidence and new referral pathways between GPs. What are your views on the best method of doing this?
 - What are your views on the 'filtering down' of evidence from NICE and DSM? (i.e. Mindfulness for depression in 2004). Does this transfer into practice?
 - Even if you don't have any lived experience in this area, you think that a mindfulness course is useful for people who experience psychosis or hear distressing voices (a new area of research)?
- Do you think there should be mindfulness course run specifically for other groups such as LGBT/people with disabilities/community groups?
- Do you know about/are you familiar with the 'nudge' agenda?
 - What are your views of the possible role of nudge to mindfulness as an area of well-being and behaviour change in terms of:
 - Mindfulness participants (sign-up rates and follow-up support)
 - GPs and practitioners
 - Is there anything that you might not have thought about before that occurred to you during this interview or that you think I should know to understand your experience of mindfulness better?
 - Is there anything else you would like to ask me?
 - Prompt: can email or call me if you think of anything at all.

How would you describe your ethnic origin?

I am

White - British

White - Irish

Other White background

Black or Black British - Caribbean

Black or Black British - African

Other Black background

Asian or Asian British - Indian

Asian or Asian British - Pakistani

Asian or Asian British - Bangladeshi

Chinese or other Ethnic background

Other Asian background

Mixed - White and Black Caribbean

Mixed - White and Black African

Mixed - White and Asian

Other Mixed background

Other Ethnic

Occupation:

Age range (circle one): 10-20, 20-30, 30-40, 40-50, 50-60, 60-70, 70-80, 80-90, 90-100

Do you consider yourself to have a disability? YES/NO

If yes, what is the name of your disability?

8. Table 2: Responses in the online survey to whether attending an MBI has affected respondents ability to deal with difficulties in their day-to-day life

Responses to effect of MBI attendance on ability to deal with difficulties in day to day life	Percent
Better pain management	1
Acceptance of limitations	3
Kinder to self	4
Reminder/addition to previous practice	5
Helps deal with stress (at work and in day-to-day life)	8
Have to keep practicing regularly to have any benefit	10
Only in a minimal way/occasionally	12
No	13
More focus/ability to pause, less reactive	21
Yes, significantly	23
Total	100

9. Details of each of the major centres of mindfulness in the UK

* **The Oxford Mindfulness Centre (OMC), Oxford**

This centre was set up in 2007, supported by a charity (the Society for the Wider Understanding of the Buddhist Tradition, whose patron is the Dalai Lama) and is led by Professor Mark Williams, one of the pioneers of Mindfulness-based Cognitive Therapy (MBCT). It is based in the Department of Psychiatry at Oxford University and works closely with the Oxford and Buckinghamshire Mental Healthcare NHS Trust and the mental health charity SANE, with a stated mission to 'realise the potential of mindfulness-based approaches in mental and physical health and to promote the well-being of people in their world of work, home and family life' (Halliwell 2010: 42).

The OMC conducts research, trains therapists and offers classes to NHS patients in the Oxford area, and runs around 6 MBCT courses a year for patients with a range of conditions, including depression, anxiety and chronic fatigue. GP referral capacity has been limited; the centre aims to facilitate its expansion. An obstacle has been the small number of health professionals trained to deliver courses, so the centre has developed teacher training pathways, ranging from a one-day introduction to mindfulness through to a two-year Master of Studies programme.

Staff at the centre have carried out research on mindfulness for patients with chronic fatigue syndrome, and projects to test its effectiveness with eating disorders and health anxiety, examined the potential for mindfulness to help pregnant women and their partners cope with childbirth and parenting, and neuroscientific research using EEG to look at the relationship between mindfulness practices and pre-frontal brain asymmetry, as a measure of "approach" versus "avoidant" styles of relating. The centre has developed a Mindfulness for schools programme, drawing on existing work with children and adolescents in the US and Australia, and has developed a syllabus that is being piloted in a dozen schools around Oxford as part of the SEAL (social and emotional aspects of learning) curriculum (ibid).

* **The Mood Disorders Centre, Exeter**

This centre is formed of a partnership between the NHS and Exeter University and supports 'the development and evaluation of novel, innovative, non-traditional, and more widely available treatments...accessible to the large numbers of people who suffer depression [and] do not respond to standard treatments' (Halliwell 2010: 42).

It uses a range of cognitive behavioural methods, including individual and group CBT, MBCT, and Mindfulness-based parent training (a new MBCT-based course aimed at helping people with a history of depression to develop parenting skills). Patients are referred through their GP or through the local well-being and access service.

Research includes studies of MBCT to prevent relapse in patients with recurrent depression and DBT for depression with personality disorder. The centre is led by Professor Willem Kuyken, and runs a part-time postgraduate training in MBCT for therapists who want to teach the approach. The first course began in 2008, with 13 students enrolled. Its activities are supported by the Devon Primary Care Trust, which is working to expand the use of MBCT across the county (Halliwell 2010: 43).

*** The Centre for Mindfulness Research and Practice, Bangor University, Bangor**

This centre was founded in 2001, is based in Bangor University School of Psychology. It has 13 full and part-time staff and 11 freelance mindfulness teachers and is the UK's biggest training organisation for mindfulness teachers, offering courses ranging from introductory and continuing professional development training to flexible part-time Masters programmes. There are also courses for the growing number of psychological therapists who want to include a Mindfulness element in, or adopt a mindful approach to, their one-to-one work with clients.

Those who register include clinical and other psychologists, psychotherapists and counsellors, GPs and psychiatrists, occupational therapists, nurses, hospice workers, health visitors, social workers, and many other professions. The centre offers Mindfulness courses to the public, including people with depression and anxiety, chronic pain, cancer, and chronic fatigue syndrome, as well as new mothers from deprived areas. The centre is self-funding, and so charges for these courses.

Another research and teaching specialty offered through the local health trust is mindfulness for people with cancer, who often face considerable mental health challenges as a result of their diagnosis. Mindfulness is also being built into the doctoral training curriculum for clinical psychologists in North Wales. The centre also involved in strategic working groups with the new North Wales regional NHS organisation, focusing broadly on psychological therapies including elements of Mindfulness (Halliwell 2010).

*** Sussex Mindfulness Centre (SMC), Sussex**

The SMC conducts research on the potential benefits of mindfulness-based interventions for groups of people for whom interventions have not traditionally been

available, and has been evaluating mindfulness-based therapies for older people, young people, for people experiencing long-term, severe depression and for people who hear distressing voices. The centre is also involved in evaluating the potential benefits of self-help mindfulness interventions.

The SMC provides mindfulness groups for service users as well as staff as part of a staff wellbeing strategy. SMC has also been offering a year-long Foundation training in Mindfulness-based Approaches (MBCT/MBSR) since 2011. More recently, it has become clear that an ever growing number of people are drawing on mindfulness in their work and using adapted mindfulness-based approaches that are not the standard 8 week programmes, such as MBCT or MBSR. Although this adapted mindfulness work often requires great skill, practitioners have not necessarily had much training in delivering mindfulness-based approaches. SMC currently has a 2015 intake on the Foundation training and applications for this training are closed until the autumn of 2016 for the 2017 intake.

Similar to the collaborative work of the Mood Disorders Centre in Exeter, the SMC centre collaborates closely with the University of Sussex, and has got several members who occupy roles within both of these institutions.

Sussex was not yet listed as one of the centres of 'Good Practice' in Halliwell's 2010 report for the Mental Health Foundation, which may be different if an update was published now due to the growth in Research & Development activities described in Chapter 6. See the latest newsletter from the centre below (Sussex Mindfulness Centre 2014)



SUSSEX MINDFULNESS CENTRE NEWSLETTER

Issue #3 – June 2015

Current news

Compassion circles for Sussex Partnership Trust staff

20 Sussex Partnership NHS Foundation Trust employees participated in Compassion Circles at Langley Green Hospital and Hillside, Newhaven for NHS Change Day on the 11th March. As highlighted in the March 2015 newsletter, (if you haven't had a chance to read it yet, you can find it on here:

<http://www.sussexpartnership.nhs.uk/activities-sussex-mindfulness-centre> - it has a great interview with Mindfulness-Based Cognitive Therapy Practitioner

Lynn Ley!) The Sussex Mindfulness Centre is interested in helping to draw out the capacity for compassion and self-compassion in the Trust. The findings from these compassion circles are currently being collated and analysed.

More information on Compassion Circles and the developer, Andy Bradley, can be found here:

http://www.sussexpartnership.nhs.uk/sites/default/files/media/frameworks_4_change.pdf or listen to Andy Bradley's TED talk <https://www.youtube.com/watch?v=eMeIRxI3-M>

UK Mindfulness Network Listing



The work of the *Mindfulness Initiative* and the All Party Parliamentary Group (APPG) has focused awareness on the question: **“How can we tell which teachers have undergone training to a sufficient standard to be safe and reliable?”** In response to this question, and the increased public profile of mindfulness, the UK Network of Mindfulness-based teacher Training Organisations (<http://mindfulnessteachersuk.org.uk/>) has felt that it is time to create a listing of mindfulness teachers.

The Network listing is based around the Good Practice Guidelines

GPGs), <http://mindfulnessteachersuk.org.uk/pdf/teacher-guidelines.pdf>

The Network is looking at a system where a teacher applying to join the listing will need to find a referee who can verify the teacher's current compliance with the GPGs. The referees will come from the training organisations within the Network.

The Sussex Mindfulness centre is a member of the Network and enables the graduates our one year training to meet the GPGs proving that they meet the ongoing requirements (supervision with an experienced mindfulness teacher, attending mindfulness CPD and all day retreats).

Taravajra (pictured above), one of the main SMC trainers, is deputy convenor this year for the UK Network.

Upcoming events

SMC master class:

“The Continuing Dialogue Between Contemporary and Traditional Teaching of Mindfulness: What to Retain? What to Relinquish? The Place of Mindfulness in the Transformation of Distress” **with Christina Feldman on Friday 12th June at the Sussex Education Centre – 9.30-5pm.**

“In classical teachings mindfulness is a multi-dimensional word and practice that is said to lead directly to the end of distress and suffering. In this workshop we will explore the questions of what mindfulness is and how it works to transform the mind. Contemporary mindfulness programmes implicitly point clients towards developing the insights that are more explicitly developed in classical practices. We will focus upon what these pivotal insights are. As well as teaching there will be times for discussion and questions during the day.”

SMC Conference

The 3rd Annual Sussex Mindfulness Centre conference will be held on Friday 18th September at the at Friends Meeting House, Ship Street, Brighton, BN1 1AF

Prof Mike West of the King’s Fund; Philippa Spicer, Managing Director of Health Education Surrey and Sussex and Andy Bradley of Foundations 4 Change are billed as keynote speakers. The theme is ‘compassion’.

To book your place at SMC events please contact on: smc@sussexpartnership.nhs.uk / 01273 716573

Drop-ins and all-day retreats

If you have completed an 8-week MBCT or MBSR course and would like to attend a short drop-in group or an all-day group retreat.

Next Mindfulness all day retreat is on **Saturday 11th July, 10am-4pm**. A limited number of mats and cushions will be provided so if possible, please bring your own mats and cushions as well as your own lunch.

Drop-ins and all day retreats take place at Sussex Education Centre on Nevill Avenue, Hove, BN3 7HZ on the Mill View hospital and Hove Polyclinic site.

Get involved

We are interested in “What do you associate with mindfulness?” Tweet @withoutstigma #mindfulnessphotos and let us know! You could even tweet us photos of objects, locations or words that you associate with mindfulness or personally remind you to give yourself a moment of mindfulness.

The Sussex Mindfulness Centre website has had a bit of a makeover. We’d love to know what you think and further ideas you have for the website. Contact us via email smc@sussexpartnership.nhs.uk or lucie.bardowell@sussexpartnership.nhs.uk

10. SPFT guidelines for referral criteria for MBCT courses

Mindfulness Based Cognitive Therapy (MBCT) group referral criteria and pathway

Referrals need to be considered on an individual basis but the following are offered as a guide to likely suitability for MBCT groups. Please read this in conjunction with the leaflet for participants, as some of the information there won’t be repeated here.

The group may help people who have most of the following:

- Repeated episodes of depression
- Anxiety and stress
- Critical self-appraisal
- Already tried a more traditional therapeutic approach and who would like to develop a more accepting relationship with themselves
- Previously tried mindfulness meditation, found it helpful and would like to deepen their practice
- A sense that a group setting would enhance rather than hinder their development
- Capacity and willingness to attend regularly over the 8 weeks and do 45 minutes of practice every day throughout the 8 weeks

The group probably won’t help people who:

- Regularly make heavy or dependent use of alcohol or other recreational drugs
- Are currently having psychotic experiences

- Have self-harmed significantly within the last year
- Have been engaged in significant acts of aggression to others within the last year
- Experience depersonalisation or derealisation as a significant and frequent feature
- Are seeking the obliteration of unbearable thoughts and feelings and who may become destabilized by mindfulness processes that sharpen their emotional awareness
- Have any condition which would make the group experience itself very problematic, such as significant dissociation, social anxiety, paranoia, difficulties in comprehension
- Have significant personal life events and experiences that would need to be explored in depth in a therapeutic situation
- Are currently experiencing, or have experienced in the last 6 months, a major life event
- For practical or emotional reasons would not be able to regularly attend the 8 week programme and who would not be able to do 45 minutes of home practice every day throughout the course

The criteria are based on research evidence and clinical experience of what has worked in previous groups. Mindfulness requires some degree of concentration, and an ability to sit with unpleasant or distressing experiences without reaching for harmful coping strategies, such as drinking or self-harming. Mindfulness practice can sharpen people's experience of their emotions and physical sensations and it would therefore not be responsible to expose people who are currently either acutely distressed or engaged in harmful ways of coping to greater emotional intensity. The group also requires a significant daily time commitment to practise, and a realistic intention to be able to make this commitment is a necessary indication of readiness to join the group.

Referral process

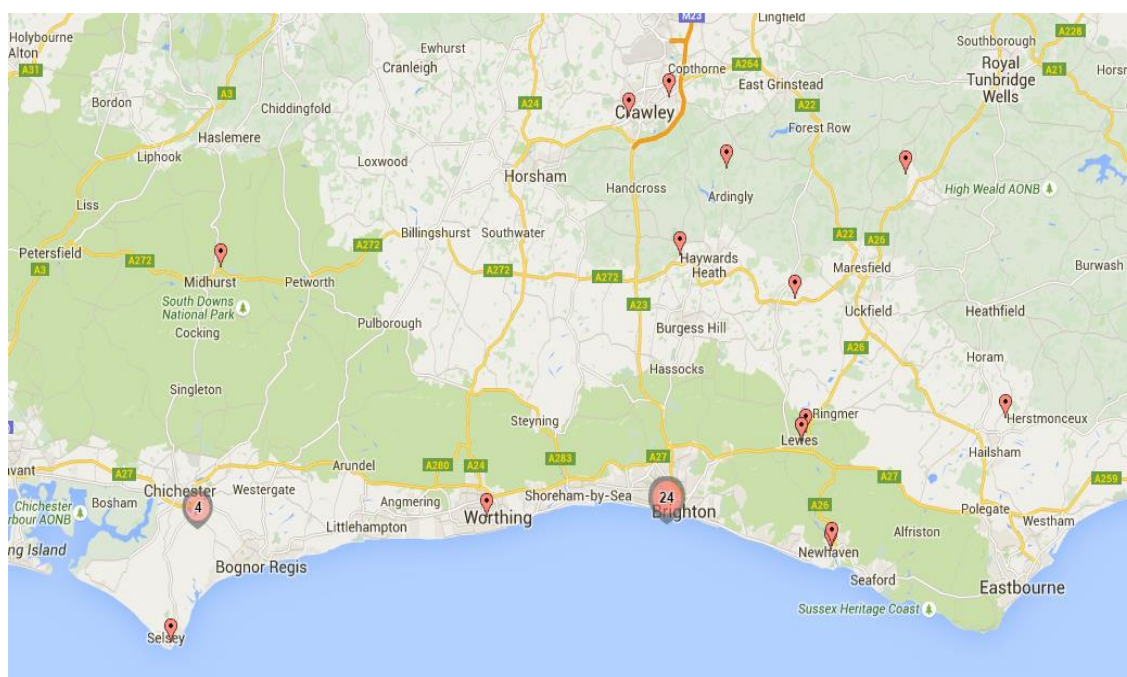
MBCT provision is currently limited in Brighton and Hove to clients in the Assessment and Treatment Service. We hope that the combination of this document and the participant information sheet will provide you and the potential group participant with enough information to come to an informed, shared decision as to whether the MBCT course seems likely to be helpful at this time. However, these criteria are meant as guideline and are not meant to be applied rigidly. Please do call and discuss your thoughts about a client if you are unsure if the group may be suitable for them.

If you have finished with the file, please send this; or else, please send significant letters or reports from ecpa to the Assessment and Treatment service, East Brighton Community Mental Health Centre, Brighton General Hospital. Please include a brief letter with an explanation of why you feel MBCT may be suitable and please ensure that the letter or the accompanying information includes:

- an account of their current difficulties
- past and current risk issues
- previous therapeutic input
- information about which mental health professional are currently working with them and who will be available if their mental health deteriorates during the course
- physical problems that may make it problematic for them to sit, stand or lie down for any length of time
- up to date contact details for the patient

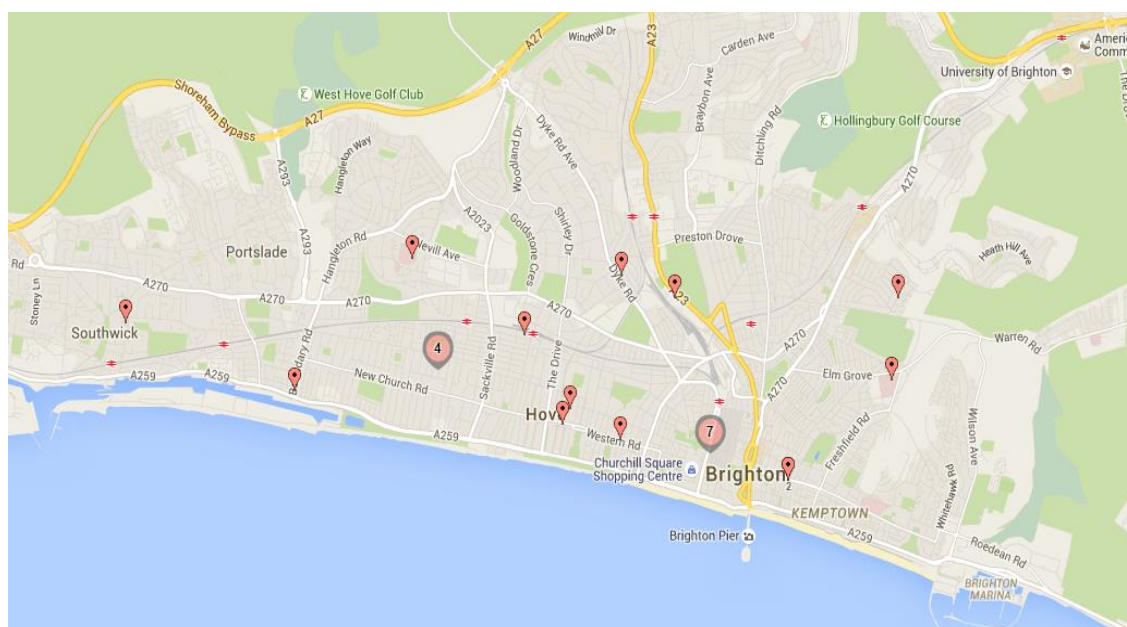
If the group is likely to be suitable, a 1-1 meeting with the person will be arranged.

11. Map 1 of MBI provision across Sussex based on data from Table 5 (below)



The red indicators show that MBI provision is strongly concentrated in the Brighton & Hove area, with 24 different services. Chichester has 4 different providers, though the remainder are mainly located across East Sussex.

Map 2 showing Brighton & Hove MBI provision from map 1 above.



12. Table 4 below shows data collected on MBI service provision across East and West Sussex. This list may not be exhaustive.

Address	Postcode	Lat/Lon g	Name of MBI provider	Course details	Cost	Take-up	Waiting list	Follow-up support
Health in Mind (HiM), 1st Floor Woodside The Drive, Hellingly, East Sussex	BN27 4ER	50.8897 67, 0.26950 7	Health In Mind (HiM)	HiM (primary care in Eastbourne/Lewes, about 9 groups per annum)				
Evolution Arts & Natural Health Brighton 2 Sillwood Terrace, Brighton, East Sussex	BN1 2LR	50.8244 48, - 0.15150 3	Brighton and Hove Council: run through Mindfulhealth.c o.uk	Courses for parent carers who are funded by Adult social carer (B&H council)				
The Lees', Horsham Road, Gossops Green, Crawley, West Sussex	RH11 8PN	51.1682 01, - 0.18963 4	Sussex Counselling & Psychology Practice: http://www.scp p.co.uk/Mindful ness.html ,	Consultative team of practitioners.	£250 for 8 week course, 1 day introductory course £60			
Copthorne, Crawley and the Cornmill Healthcentre, East Grinstead, West Sussex	RH10 7DX	51.1433 63, - 0.11293 5	www.themindfu lorg.co.uk	<ul style="list-style-type: none"> • Introductory One Day Mindfulness Courses • 8-Week Mindfulness Courses • 1:1 Mindfulness based Coaching and Therapy • Mindfulness for Couples 	£250 per person Includes a 1-hour one to one exploration/orient ation session, 1 Day Mindfulness			

				• Mindfulness based Art Therapy Courses	Retreat, course manual and guided practice CDs.			
Mill View Hospital, Nevill Avenue Hove, East Sussex	BN3 7HY	50.8428 32, - 0.18927 2	Sussex Mindfulness Centre	Open to anyone who has both completed an eight-week MBCT or MBSR group and who is either a current or ex service-user, or current employee of Sussex Partnership	Free			
Fourth Floor, 177 Preston Road	BN1 6AG	50.8383 81, - 0.14833 6	Brighton & Hove Wellbeing Service	Mindfulness courses delivered by Talking Therapies team. Need assessment and self-referral or through GP	Free			
Corner House Resource Centre 45 Southwick St Southwick, West Sussex	BN42 4TH	50.8353 97, - 0.23455 7	Recovery College	4 hours in total introductory course aimed at anyone experiencing mental health difficulties who is interested in finding out more about Mindfulness.	Free			
The Aldrington Centre 35 New Church Road, Hove, East Sussex	BN3 3AG	50.8300 75, - 0.18416 2	Brighton CAMHS	In house within the service (B&H CAMHS)				
Denton Island Community	BN9 9BA	50.7962 96,	NCDA (Newhaven	MBCT course at Sussex Downs College	£21 which covers the cost of the	13 people on average	No waiting list	

Centre, Denton Island, Newhaven, East Sussex		0.049030	development association). Email: enquiries@ncda.org.uk	(Newhaven Campus)	materials (books/CD's)	attending courses, mainly women (10), men (3)		
Different locations across West Sussex			Time to Talk: Various Teams. http://www.sussexcommunity.nhs.uk/services/timetotalk/t2t_locations.htm	MBCT				
10 Bevendean Road, Brighton, East Sussex	BN2 4DE	50.839498, -0.112384	Sussex Beacon. HIV service. http://www.sussexbeacon.org.uk/mindful.html	9 week MBCT/MBSR course (called Mindful Living). Aim to help people who are HIV +ve find ways of living in the present moment. Run once a year and have been running courses for 6 – 7 years	Free at point of delivery. Funding from charities (we have a grant fundraiser and Mindfulness is often funded by a grant). Also sponsored by the Monument Trust	Average number of participants: 14. Average number completing course: 9. Courses open to any HIV+ve person living in Sussex – however participants are mainly residents in the Brighton area. Due to the demographics of HIV in Brighton the greatest percentage of attendees are		Once course is completed participants are invited to attend monthly 2hr mindfulness group and every 6 – 8 weeks a whole day of mindfulness (this is also at no cost to the participants and is funded via charity monies). Numbers wishing to

						male. Age range: 25 – 70yrs		attend follow up group is 25 – average number of attendees at each monthly and day of mindfulness = 8
17 Tichborne Street, Brighton, East Sussex	BN1 1UR	50.8250 03, - 0.13993 7	Brighton Buddhist Centre: http://www.brightonbuddhistcentre.co.uk/health.html#eastbourne	MBCT, Mindfulness for Pain Management - Living Well with Pain & Illness,	£130, £125			Offer a monthly drop in class at the Buddhist centre for anyone who has completed an MBCT course and have also offered 'level 2' course. A monthly drop-in class for people who have completed a Mindfulness Based Cognitive Therapy for Depression and Stress course (either

								at the Brighton Buddhist Centre or at Evolution). Cost: £5 (£3 conc.)
3 Boundary Road, Hove, East Sussex	BN3 4EH	50.8299 77, - 0.20817 6	Social Enterprise Complementary Therapy Company (SECTco): http://www.sectco.org/	MBCT course	Donation			
Community Base 113 Queens Road, Brighton, East Sussex	BN1 3XG	50.8258 03, - 0.14228 5	MINDOUT (lesbian, gay, bisexual and transgender charity)	MBCT 8 week course run by and for LGB&T people: email info@mindout.org.uk , or phone 01273 234 839, also a Mindfulness Day run on April 14th 2013 (£20/10).	£90 full price, £20 concessions. No external funding to run more courses, they are all now funded by us.	Usually 12-14 people per course. Do not keep records of applicants vs. people attending (of which there were 15 on this course, and of the 9 weeks (8 plus intro session) there were 110 attendances out of a possible 135).		Free Refreshers for anyone who has previously been on an MBCT course (only been 2 run). This is the first refresher MindOut has run. A follow up session in 4 weeks, and day of practice (usually one per year). Take up varies, can be

								very low, but the last one was about 80%.
Dyke Road Clinic, 274 Dyke Road, Brighton, East Sussex	BN1 5AE	50.8417 66, - 0.15827 1	http://mindfulnessforwellbeing.co.uk/	Introductory sessions (1 hour), and 8 week MBSR course.	Introduction session free. 8 week MBSR £160 (£110 concession). Includes a substantial Course Handbook and four guided meditation CDs.			
Tree of Life Clinic 143 Portland Road, Hove, East Sussex	BN3 5QJ	50.8334 72, - 0.18622 8	http://mindfulnessforwellbeing.co.uk/	Introductory sessions (1 hour), and 8 week MBSR course.	Introduction session free. 8 week MBSR £160 (£110 concession). Includes a substantial Course Handbook and four guided meditation CDs.			
Subud Centre, 26a Station Street, Lewes, East Sussex	BN7 2DB	50.8724 65, 0.01069 6	http://mindfulnessforwellbeing.co.uk/	Introductory sessions (1 hour), and 8 week MBSR course.	Introduction session free. 8 week MBSR £160 (£110 concession). Includes a substantial			

					Course Handbook and four guided meditation CDs.			
Kings Church, Lewes Brooks Road, Lewes East Sussex	BN7 2BY	50.8774 47, 0.01654 4	http://mindfulnessforwellbeing.co.uk/	Introductory sessions (1 hour), and 8 week MBSR course.	Introduction session free. 8 week MBSR £160 (£110 concession). Includes a substantial Course Handbook and four guided meditation CDs.			
Anahata Health Clinic, 119/120 Edward Street, Brighton, East Sussex	BN2 0JL	50.8216 98, - 0.12995 6	http://mindfulnessforwellbeing.co.uk/	Introductory sessions (1 hour), and 8 week MBSR course.	Introduction session free. 8 week MBSR £160 (£110 concession). Includes a substantial Course Handbook and four guided meditation CDs.			
			http://mindfulnessforwellbeing.co.uk/	Mindfulness-based Cognitive Therapy for Reducing Stress, Depression and Anxiety	£150 (£100 concession). Includes a 76 page Course Handbook and four guided meditation CDs.			

Marshall Lane, Newhaven, East Sussex	BN9 9RB	50.7934 90, 0.04812 1	Summerhayes Wellbeing Centre in Newhaven: http://www.escis.org.uk/Entry/View/Summerhayes_Well-Being_Centre/13964	Very low cost courses in Sussex organised through Summerhayes wellbeing centre in Newhaven,				
Anahata Health Clinic, 119/120 Edward Street, Brighton, East Sussex	BN2 0JL	50.8217 25, - 0.12990 2	Anahata Health Clinic, 119/120 Edward Street	Hybrid of MBSR and MBCT which is mainly aimed at people suffering with stress and anxiety. Small groups of up to 8 people and have been getting a lot of 1-1 work recently.	£100/150 for 8 week group course, £380 for eight 90-minute sessions, £450 for eight 2-hour one-to-one sessions.	70/30 women to men despite trying with publicity material to look neutral. Ethnicity about average for Brighton; mostly white but not exclusively so. No obvious bias there.	No waiting list but courses are often full and anticipate numbers growing over time.	Have offered a few follow-ups but take up was not great; I put that down to the huge amount of meditation and yoga groups in Brighton.
					Cost £10 (£8 concs) for follow-up	Take up figures vary enormously-classes were full last term with a waiting list (max 10- 14 participants depending on the venue) This term some		Do 'refresher sessions' and a few people keep coming back to these. MBCT 'Refresher' Session, Sunday 30th September. This session

						of them had only 7 or 8. Ethnicity – mostly Caucasian though I get quite a few from various European countries. Gender – 90% women. Many of my classes are women only. At most I'll get 3 or 4 men in a group usually just one or two		will be an opportunity to reconnect with the practices and spirit of the MBCT course. The intention is for this to be a resource to help people support, and if necessary re-invigorate their practice.
The Jacobean Hall at The Old School, Cuckfield, Haywards Health, West Sussex	RH17 5JZ	51.0054 88, - 0.143062	Mindfulness Sussex: http://mindfulnesssussex.co.uk/	8-week courses, one-day intro workshops and twice-monthly graduate sessions. Also various work in organisations, daytime and evening Mindfulness-Based Stress Reduction (MBSR) courses and one-day 'Introduction to Mindfulness' workshops	The cost of the course is £225 which includes the 8 weekly sessions, CDs, course materials and the day retreat. Pre-registration is essential for all our courses. Each session costs £10 (£11 from January 2013). We are currently	Courses are generally full. 14 for an 8wk course, 16 for a 1-day workshop. Grad sessions approx 10-15 per session	Yes is a waiting list	Have a 'Graduates' webpage and program: http://mindfulnesssussex.co.uk/graduates.html . Graduate Practice Retreats Graduate retreats offer a chance to reconnect with the practices

					<p>offering all ten 2013 sessions for £75 if you book for them in one payment. Graduate retreats cost £45 and include light refreshments mid-afternoon. MBSR 8-week Course Retreats (numbers permitting) Where numbers permit we offer the opportunity to come to one of our current 8-week MBSR course retreats at a cost of £30.</p>			<p>and to take them deeper. 12.30 - 6.00pm. 4x year graduate mornings and 2x year grad retreat days. 1x year graduate residential weekend.</p>
Psychology Sussex 6, The Drive, Hove, East Sussex	BN3 6JA	50.8277 66, - 0.16869 7	Choose Mindfulness: http://www.choosemindfulness.com/		£195			
16 Station Street, Lewes, East Sussex	BN7 2DB	50.8742 03, 0.01793 9	Equilibrium Clinic: http://www.equilibrium-clinic.com/class	MBCT for wellbeing course.	£150 (£100 concession). Includes a 76 page Course Handbook and			

			es_workshops. htm. http://mindfulnessforwellbeing.co.uk/		four guided meditation CDs. (free introduction)			
2 Sillwood Terrace, Brighton, East Sussex	BN1 2LR	50.8246 45, - 0.15142 2	Evolution Arts Centre: http://www.evolutionarts.org.uk/mbct	10 week MBCT	£130 for Monday course, £115/85 for Tuesday course (why the difference?)	MCRA (Newhaven)		
Mind Central Office. 51 New England Street, Brighton, East Sussex	BN1 4GQ	50.8329 90, - 0.14067 6	MIND: http://www.mindcharity.co.uk/newsarticle.asp?id=228	1 day course in Training in the Skills of Mindfulness Practice	£60 voluntary sector / £80 statutory & private sector			
Headway Hurstwood Park Headway House Jackies Lane, Newick, East Sussex	BN8 4QX	51.0552 92, 0.18039 0	The Link Centre: http://www.thelinkcentre.co.uk/99.html ,	MBSR	£250	Team psychologist for current options		
123a Western Road, Brighton, East Sussex	BN3 1DB	50.8254 76, - 0.15673 7	Revitalise. http://www.revitalise-u.com/hove/therapies/mind-based-therapies/mindfulness-based-cognitive-	MBCT	£45 per hour			

			therapy-mbct					
			Mindfulness Brighton, http://www.mindfulnessbrighton.co.uk/index.html . Teaches at various venues including Anahata.	MBCT	£380 one-to-one. 8 week MBCT and MBSR combined: £150, £100 concessions.			
The Mansion, Wakehurst Place, Selsfield Road, Ardingly, West Sussex	RH17 6TN	51.0681 80, - 0.088063	The Mindful Organisation, http://www.themindfulorg.co.uk/mindfulnesscourses.shtml .	8 week 'mindfulness course for stress' & mindfulness drop-in groups	8 Week Mindfulness Course Dates for 2012 - £250			
Cornerstone Community Centre, Church Road, Hove, East Sussex	BN3 2FL	50.8269 22, - 0.165215	Hove Stress Busters http://www.hovestressbusters.co.uk/pages/clinics.html#self-hypno	Drop-in workshops on the last Monday of every month: The sessions are suitable for beginners as well as for anyone wishing to practice and extend their existing mindfulness skills. Admission: £10 per session	2 hour drop-ins are £10 per session. Course fee: £125 £110*/£77 conc. The course fee includes six 90 minutes long weekly sessions and handouts. Payment plan available upon request.			
The Tree of Life Centre	BN3 5QJ	50.8334 78, -	Dheeresh Turnbull-	Hove Zen & Mindfulness Sangha' (formerly	£175 for the whole thing,	Not much marketing time,		The drop-in group was set

143 Portland Road, Hove, East Sussex		0.185893	http://www.learningtoplayyourmind.com/ ,	<p>'Undercover Dharma': drop-in mindfulness/zen meditation meets every Monday except bank holidays; plus qi gong (2nd week of month); big mind (last week of month). 7.15 - 8.45pm at Westwerks (www.werkshop.org.uk/west-werks), 41-43 Portland Road.</p> <p>'Enhanced' Mindfulness-Based Stress Reduction (E-MBSR) courses - New course postponed until 6th June. 8 Fridays, 4-6pm for eight sessions (not meeting Friday 23rd July). It will be at Westwerks, 41-43 Portland Road, Hove.</p> <p>Also 8 Thursday evenings 7.30-9.15pm.</p> <p>My drop in group is affiliated to the Wild Goose Zen Sangha, and we meet weekly on Mondays, Mondays at 7.15pm @ Westwerks, 41-43 Portland rd Hove.</p>	including materials (book, DVD, CD, access to cushions).	so numbers are quite small - starting one tomorrow with three or four.		up as a follow up for people who had done the eight week course (either with me or anywhere), but it began to attract people who hadn't done it and didn't want to turn anyone away. Over several years it has morphed into a (primarily) Zen group, but still mention it to people who have done a course as one way of keeping up practice. Called 'The Hove Zen & Mindfulness Sangha' which gives you an idea of the range.
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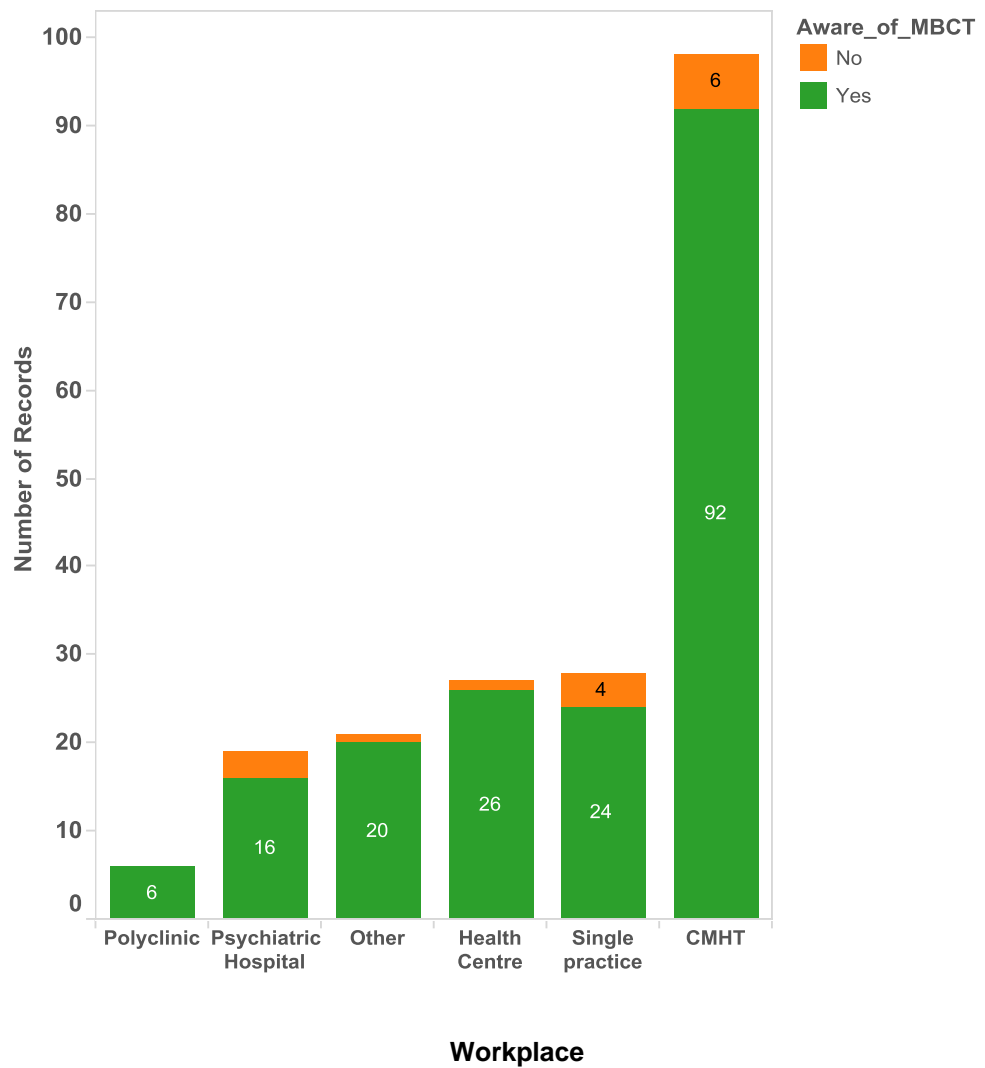
Westwerks, 41-43 Portland Road, Hove, East Sussex	BN3 5DQ	50.8328 24, - 0.18041 2		My drop in group is affiliated to the Wild Goose Zen Sangha, and we meet weekly on Mondays				
28 New Road, Brighton, East Sussex	BN1 1UG	50.8241 56, - 0.13938 6	New Road Consultancy nrc@newroadc onsultancy.com http://www.new road.co/therapi sts/find-a- therapist/rory- singer/					
Friends Meeting House Priory Road, Chichester, West Sussex	PO19 1NX	50.8381 15, - 0.77538 3	http://www.dail ymindfulness.c om/courses.	MBSR. Tuesday, Wednesday and Thursday evenings for 8 weeks (in different locations) (with the exception week 5 which will be held on Monday Feb 11th) from 7 – 9.30pm, starting on January 15th 2013 and finishng on March 5th 2013. There will be a 'day' of Mindfulness 10.30 am – 4pm at Cowdray Hall on February 24th which is part of the programme. I hold several Monthly Mindfulness Meetings in	CancerWise in Chichester £3 or donation and free to those with cancer	Groups vary from about 3 people to 15 mostly female only one person has been disabled (wheelchair), unless you count cancer an it's affects as a disability.	There is no waiting list for these drop-ins. Advertise the drop-ins in newsletters and on website, they are advertised in the venues newsletters and on their websites.	Take-up for follow-ons vary and has not been quantified

				three different venues, these are drop in groups but CancerWise is the only drop in centre.				
Hamblin Hall, Bosham House Main Road Bosham, Chichester, West Sussex	PO19 1NX	50.8427 52, - 0.85652 4			Hamblin Hall £7 in Bosham			
Cowdray Hall Parkway, off Easebourne Street Easebourne, Midhurst, West Sussex	GU29 0AL	50.9958 99, - 0.72456 6			Cowdray Hall £10 in Midhurst.			
Friends Meeting House, 6 Victoria Drive, Bognor Regis, West Sussex	PO21 2RJ	50.7817 16, - 0.68428 6	http://www.clair.ecolecounselling.co.uk/Mindfulness.htm	8 week MBCT course, 8 week Mindfulness course for couples. Mindfulness Based Cognitive Therapy Course to small groups of up to 10 people.	£250 for general course including handouts and CDs of the meditations for home practice. The length of each session is 1.5 hours. Couple MBCT is £350 and small group £150. Donation only for the drop-in. The session runs between	Small (6-10 max). Getting people to commit can be challenging and as a result only running one a year for the general public. Currently running a course for teachers at the moment and my	No waiting list	Runs drop-ins and day retreats for graduates of other 8-week courses. run a monthly drop in for any participant of any 8 week course.and also the occasional stand alone retreat day.

					7.15pm and 8.45pm. Day retreat for graduates is £25	next course is for NHS staff. Mostly women, age range of mid 20s to late 60s.		
			http://crowboroughmeditation.com/healing.html	9 week mindfulness courses (not MBCT or accredited)	£10 per session			
Henry House in Heene Road, Worthing, West Sussex	BN11 4NN	50.8178 25,- 0.38667 1	Circle of Support Counselling and Therapy http://www.circleofsupport.co.uk/mindfulnessworkshops.html	6 week mindfulness course (not accredited: course structure seems adapted from MBCT).	£95 for 6 weeks	In the first course had 7 participants: 1 male, 6 female. 2 in their 30s, 2 in their 40s and 3 early 60s. All White british. No disabled.	No waiting list but don't really advertise, courses filled by word of mouth.	Intend to hold morning refreshers regularly. £10 per session
The Hive, Stoneham Park, Hove, East Sussex	BN3 5FS	50.8344 60, - 0.18500 8	Mindful for Life. http://www.mindfulness4life.co.uk/#!/courses/cvaw	MBSR and MBCT 4 week introductory courses.	Free 1 hour taster. 4 week intro MBSR course £65. MBCT £110/£90 concs			
Horder Healthcare, St John's Road, Crowborough, East Sussex	TN6 1XP	51.0637 02, 0.14278 5	Julie Stannard. http://www.clearmindinstitute.co/members/julie-stannard/	Two different 8 week courses at present MBSR and Mark William's Frantic World course (details as per website)	For mbsr cost was £230 and included workbooks, 2 hour weekly sessions and half day of	Have offered 3 sessions over 4 months and have 5-6 people in each (offered to all previous participants)	Full take-up of the 8 places (limited by room size) for the last two	I offered two follow up sessions previously and there was reasonable take-up.

					mindfulness practice.	Next course: 8 female, white european.	courses. This time oversubscribed by one. On waiting list for next time.	
Chichester Holistic centre in Forum House, Stirling road, Chichester, West Sussex	PO19 7DN	50.8337 03, - 0.77427 6	http://www.amanda-ashmanwymbbs.co.uk/ ,					
			http://mindfulnesswork.com/ . Training and consultancy for organisations.					
14 St George's Place, Brighton, East Sussex	BN1 4GB	50.8276 36, - 0.13571 2	Brighton Therapy Centre: http://www.brightontherapycentre.org.uk/therapies/mindfulness-based-therapy/ .	8 week MBCT course	£135 paid in advance when you book your place. Fee inclusive of CD and course book. We have a limited number of concessions for senior citizens, and those on low income.	10 people per course, one or two usually fall through at last minute so it runs with eight or nine.	People have to start for the nearest course to run, which can be up to two months, but generally don't turn people down or make them	1 day. Yes it is, take up is varied, take up is lower than the course itself, averaging on around five or six people is my best guess.

							wait for the next course before the current one has started.	
50 Grafton Rd, Selsey, Chichester, West Sussex	PO20 0JE	50.7276 30, - 0.78650 2	Mindfulness Meditation Zone, ('Mindful 'i' program): http://www.mindfulnessmeditationzone.com/mindfulness-meditation-chichester/ . Mindful Living and Practical Meditation for Adults, Kids and Stressed-Out Executives http://www.mindfulnessmeditationzone.com/01243601236	8 week courses in 'Mindfulness Living and Practical Meditation'	Approx £210 for the 8 weeks.	Approx.75% female between 45-82 years. About 33% mentioned they were attending for themselves but also to find ways to help somebody close to them. Nearly all attendees based on the above are of white origin and have a certain level of disposal income because of the charge for the sessions		Follow up is generally based on some level of coaching or additional sessions (and some include course notes). Just launched a DVD now available on Amazon and have an online Mindfulness course people can benefit from at home.

13. Graph 4 Awareness of MBCT by workplace within SPFT

13. ASPIRE study protocol

Title: Accessibility and implementation in UK services of an effective depression relapse prevention programme:
Mindfulness-based cognitive therapy (MBCT)

REC Ref:

Chief Investigator: Prof Willem Kuyken and Prof Jo Rycroft-Malone

Summary of Research

Mindfulness-based cognitive therapy (MBCT) is a cost effective psychosocial prevention programme that helps people with recurrent depression stay well in the long term. It was singled out in the 2009 National Institute for Health and Care Excellence (NICE) Depression Guideline as a key priority for implementation (1). However, its accessibility across the UK is both limited and inequitably distributed (2).

Depression is a major public health problem that, like other chronic conditions, typically runs a relapsing and recurrent course, producing substantial decrements in health and considerable human suffering (3). In terms of disability-adjusted life years, the World Health Organization consistently lists depression in the top five disabling conditions and forecasts that this will worsen over time (4). While mental health problems are as common and debilitating as physical health problems, unlike physical health problems only ¼ of those who suffer mental health problems receive treatment. Indeed, while 23% of the total burden of disease is attributable to mental health problems, only 13% of NHS health expenditure is spent on mental health (5). Without effective treatment, people suffering recurrent depression have a high risk of repeated lifetime depressive episodes. Major inroads into the substantial health burden attributable to depression could be offset through making accessible evidence-based interventions that prevent depressive relapse among people at high risk of recurrent episodes (6).

To stay well NICE recommends that people with a history of recurrent depression continue antidepressants for at least two years. However, there are many drivers for psychosocial interventions that provide long-term protection against relapse (7). There is significant interest in a promising psychosocial intervention: mindfulness-based cognitive therapy (MBCT), which was developed to teach people with a history of depression the skills to stay well in the long term (8). A recent systematic review (9) and the 2009 NICE depression guideline (1) suggest MBCT is an effective depression relapse prevention programme.

Even if a psychosocial intervention has compelling aims, has been shown to work, is cost-effective and is recommended by a government advisory body, its value is

determined by how widely available it is in the health service. Feasibility work for this application shows that NHS provision of MBCT falls well short of that envisaged in the UK national guidance (2). A recent British Medical Journal editorial suggests that research is needed to answer the questions ‘What are the facilitators and barriers to implementation of NICE’s recommendations for MBCT in the UK’s health services? Can this knowledge be used to develop an Implementation Plan for introducing MBCT consistently into NHS service delivery?’ (10).

Research aims

The proposed research will ascertain the current state of MBCT implementation across the UK and develop an Implementation Plan. Specifically we will:

- Scope existing provision of MBCT in the health service across England, Northern Ireland, Scotland and Wales.
- Develop an understanding of the perceived benefits and costs of embedding MBCT in mental health services.
- Explore facilitators that have enabled services to deliver MBCT.
- Explore barriers that have prevented MBCT being delivered in services.
- Articulate the critical success factors for the routine and successful use of MBCT as recommended by NICE.
- Synthesize the evidence from these data sources, and in consultation with stakeholders, develop an Implementation Plan that services can use to facilitate the implementation of MBCT.

Study Framework

We will use the Promoting Action on the Implementation of Research in Health Services (PARIHS) to underpin this study (11, 12). The work will involve a two-phase exploratory and explanatory research study, using an interview survey and in depth case studies.

Phase 1 will provide a broad overview of current implementation across the UK using an interview survey. Up to 70 purposively sampled semi-structured telephone or face-to-face interviews with a range of stakeholders across UK services will be conducted. We will scope existing provision and focus on perceptions about MBCT, ascertain views about embedding MBCT into service delivery, including models of teacher training, facilitators, barriers, costs and benefits.

Phase 2 will provide a contextually rich picture of MBCT service delivery through 10 in-depth case studies using exploratory and interpretive methods. A ‘case’ is defined as

an NHS Trust, Health Board or commissioned organization¹⁴⁰ where NICE recommendations would suggest there should be MBCT provision. We are interested in uncovering what the critical success factors are for the routine and successful use of MBCT as recommended by NICE for people with recurring depression in service delivery. Additionally, we want to know what impedes the routine use of MBCT. In each case study we will conduct semi-structured interviews with service users, managers, commissioners, and practitioners, non-participant observation of relevant meetings, and document analysis.

Across both phases purposive sampling will ensure each key UK geographical region is represented. Moreover, within each region we will sample across different levels of implementation and key contextual variables and from the available cases sample randomly.

Data will be analyzed using a thematic analysis approach informed by Ritchie and Spencer (13), and Yin (14).

Synstudy and outcomes: Guided by the study's conceptual PARIHS framework and located within the MRC Complex Interventions Framework, data will be synthesized across phase 1 and phase 2 to provide a rich and robust explanation about MBCT implementation in UK health services. The output of this will be an MBCT Implementation Plan, which will include a toolkit (i.e., strategies for successful implementation, implementation approaches, training manuals, measurement/evaluation tools) for service providers to use to facilitate more successful implementation of MBCT into service delivery. This will include tools for evaluating the impact of implementation on key outcomes.

Benefits to the NHS

Depression typically presents in the NHS as a recurrent, long-term condition associated with significant disability and repeated presentation to services. By improving the accessibility of a cost-effective psychosocial intervention programme many more people will be able to benefit by reducing their risk for depressive relapse and enjoying improved quality of life and functional status. In addition, the substantial costs associated with depression would be offset. This study could have considerable impact given the size of the problem being addressed (recurrent depression) the modest cost of the intervention and the way MBCT could integrate with care pathways for depression in existing mental health services. Our dissemination plan includes a

¹⁴⁰ The Health and Social Care Act 2012 requires Primary Care Trusts to transfer clinical service contracts to new commissioning organizations and we will refer to the services commissioned by these new groups.

proactive and collaborative approach to ensuring the Implementation Plan is accessible and used across the NHS.

Background and Rationale

The proposed research is concerned with producing rigorous and relevant evidence on the quality, access and organization of health services through scoping current best practice of implementing NICE guidance on MBCT to develop an MBCT Implementation Plan that addresses a major public health problem (depression). This work will be of direct benefit to NHS services in providing a resource to support the implementation of a key priority for implementation identified in the 2009 NICE depression guideline. Finally, this study will have the potential both to develop into a larger scale implementation trial and to inform future work on MBCT with other long-term conditions (8).

Depression is a major public health problem that, like other chronic conditions typically runs a relapsing and recurrent course, producing substantial decrements in health. The average age of the first episode of major depression is the mid-20s and, although the first episode may occur at any time from early childhood through to old age, a substantial proportion of people have their first depression in childhood or adolescence. Incomplete recovery and relapse are common. Without ongoing treatment people suffering recurrent depression tend to have high rates of relapse and recurrence (15). In terms of disability-adjusted life years, the World Health Organization consistently lists depression in the top five disabling conditions and forecasts that this will worsen over time (4). While mental health problems are as common and debilitating as physical health problems, unlike physical health problems only ¼ of those who suffer mental health problems receive treatment. Indeed, while 23% of the total burden of disease is attributable to mental health problems, only 13% of NHS health expenditure is spent on mental health (5). Health economic analyses of the cost of anxiety and depression in the UK suggest a cost of £17 billion or 1.5% of the UK gross domestic product (5, 16). A major factor contributing to the economic effects of depression is the reduced capacity that sufferers have to engage in the work place.

Major inroads into the health burden attributable to depression could be achieved by making evidence-based approaches to prevention more accessible to patients at risk for recurrent depression (15). Currently, the majority of depression is treated in primary care, and maintenance antidepressants are the mainstay approach to preventing relapse. To stay well NICE recommends that people with a history of recurrent depression continue antidepressants for at least two years. However, there are many drivers to consider psychosocial interventions that provide long-term protection against

relapse. The majority of patients express a preference for psychosocial approaches that can help them stay well in the long-term; antidepressant medication can have unwanted side effects; rates of adherence with medication regimes tend to be poor and in the perinatal period many women prefer an alternative to psychotropic medication (7).

Mindfulness-based cognitive therapy (MBCT)

To address this need, mindfulness-based cognitive therapy was developed as a psychosocial intervention intended to teach people with a history of depression the skills to stay well in the long term (8). Mindfulness-based cognitive therapy is a manualized psychosocial, group-based relapse prevention programme for people with a history of depression who wish to learn long-term skills for staying well. It combines systematic mindfulness training with elements from cognitive-behavioural therapy. It is taught in classes of 8-15 people over 8 weeks. Through the mindfulness course people learn new ways of responding that are more self-compassionate, nourishing and constructive. This is especially helpful at times of potential depressive relapse, when patients learn to recognise habitual ways of thinking and behaving that tend to increase the likelihood of relapse and can choose instead to respond adaptively. In line with the MRC Complex Interventions Framework and leading commentators (17), MBCT has a session by session treatment manual that specifies in detail the content of the intervention (18). There is evidence of its acceptability to patients and referrers (19, 20) and the UK Network for Mindfulness-based Teacher Trainers has set out good practice guidelines for training and clinical supervision, see:

<http://mindfulnessteachersuk.org.uk/#welcome>.

A recent British Medical Journal editorial sets out the key characteristics of an MBCT service (10), which includes commissioning MBCT in line with NICE guidance and setting up well articulated care pathways. Moreover, it is important that practitioners are appropriately trained / supervised and deliver the intervention in line with the treatment manual.

Systematic review and the need for this project

A recent systematic review and meta-analysis of six randomised controlled trials ($N=593$) suggests mindfulness-based cognitive therapy significantly reduces the rates of depressive relapse compared with usual care or placebo controls, corresponding to a relative risk reduction of 34% (risk ratio 0.66, 95% confidence intervals .53, .82) (9). This led NICE to conclude, "Of the treatments specifically designed to reduce relapse group-based mindfulness-based cognitive therapy has the strongest evidence base with evidence that it is likely to be effective in people who have experienced three or

more depressive episodes” (1). There is preliminary evidence that MBCT is cost effective compared with the current treatment of choice, maintenance antidepressants (21). None of the published trials report adverse events or harm. Even though MBCT has compelling aims, has been shown to work, is probably cost-effective and is recommended by a government advisory body, the existing body of research does not address implementation. The next phase of work is to determine how MBCT can be implemented in “uncontrolled real world” healthcare settings (10). A search in Web of Knowledge, Science Direct and Google Scholar using the terms “Mindfulness-Based Cognitive Therapy,” “MBCT,” “mindfulness + implementation,” “mindfulness + knowledge transfer” yielded only two studies (2, 22). Therefore the potential to create new knowledge in this study is significant.

Feasibility work and identification of case studies

Feasibility study. One of the two extant implementation studies was completed as a feasibility study for this project by two of the applicants (2). This study asked to what extent MBCT has been implemented in the health service to date and what had facilitated implementation. It was based on: (i) a stakeholder workshop (N=57), (ii) a postal survey (N=103) and (iii) an overview of four services that had either partially or fully integrated MBCT services. The results suggested that accessibility across the UK is very limited. Eighty one per cent of respondents reported that the implementation of MBCT had not yet begun in their organization. Where implementation had started, very few respondents reported a strategic and systematic approach to implementation. Instead, successful implementation was most frequently described as being due to “enthusiasts” who had driven through change, but that these initiatives largely lacked organizational commitment or integration with other services. The authors note that the limited implementation of MBCT contributes to health inequalities and misses an opportunity to translate evidence into practice. This feasibility study was based on convenience samples and was largely descriptive. However, it does not offer an explanation of why MBCT implementation to date is so patchy and inequitably distributed – hence the need for this study.

Preparation for proposed study. Since submitting the outline, we have secured access to all the required interview survey and case study sites for the proposed research (see Section 5.3 below). We have found that services have been highly motivated to engage because they can see benefits of participation to their service specifically and NHS mental health services more generally.

Relevance to the NHS

This question is highly relevant to the NHS because the scale of the problem of depression is so large. Depression that presents in the NHS is often chronic and recurrent, so prevention is key to successful management. MBCT has the potential to be an acceptable and cost effective approach to prevention that can readily be incorporated into the depression care pathway. One of the outputs of the research will be an MBCT Implementation Plan that will be developed so as to be useful to mental health service managers, commissioners and MBCT teachers.

Why is this research needed now?

- The NHS, new NHS Commissioning Board and NICE are committed to improve patients' experience of healthcare, to ensure high quality services, and to achieve the best possible outcomes (23). This includes a commitment to ensuring that cost effective NICE recommended treatments are equitably accessible across the UK (24).
- Northern Ireland (25) and Wales (26) have recently started implementing new national strategies for psychological therapy service provision, while Scotland (27) and England (16) are several years into implementing national strategies for increasing access to psychological therapies. In each of these contexts the question of how best to provide an integrated care pathway for treating *and preventing depression* is timely (5).
- The 2010 Mental Health Foundation Mindfulness Report includes a survey of service users and GPs that suggested both groups have a significant interest in seeing MBCT more widely accessible in the health service (19).
- Our feasibility work (2) suggests systematic implementation is not happening in the NHS, but we do not have a comprehensive picture about why, nor what is needed to facilitate successful implementation.
- This is a time of considerable change in mental health services; this presents opportunities for innovation.
- New Academic Health Science Networks prioritize “translating research and learning into practice” and “ensuring and supporting the adoption and spread of the nationally designated innovations” (28).
- There is a growing evidence base and developing theory about implementation - i.e., bridging the gap between evidence and practice through the study of methods to promote the uptake of research into routine practice and understanding what influences these processes (29-31). This research will contribute to this evidence base.

Implications for the proposed project

In summary, it is timely to establish why MBCT is not currently standard practice across services in the UK. A recent British Medical Journal editorial proposed that we need an answer to the questions: ‘What are the facilitators and barriers to implementation of NICE’s recommendations for MBCT in the UK’s health services? Can this knowledge be used to develop an implementation plan for introducing MBCT consistently into NHS service delivery?’ (10). These are the questions being addressed in this study.

Aims and objectives

Informed by the preparatory work outlined above, this research will describe the current state of MBCT implementation across the UK and develop an explanatory framework of what is hindering and facilitating its progress. From this framework we will develop an MBCT Implementation Plan for NHS services.

Specifically we will:

- Scope existing provision of MBCT in the health service across the four UK countries.
- Develop an understanding of the perceived benefits and costs of embedding MBCT in mental health services.
- Explore facilitators that have enabled services to deliver MBCT.
- Explore barriers that have prevented MBCT being delivered in services.
- Articulate the critical success factors for the routine and successful use of MBCT as recommended by NICE.
- Synthesize the evidence from these data sources, and in consultation with stakeholders, develop an MBCT Implementation Plan that services can use to facilitate the implementation of MBCT.

Research Plan / Methods

Design and theoretical/conceptual framework

Framework. We will use the Promoting Action on the Implementation of Research in Health Services (PARIHS) (11) to underpin this study – $SI = f(E, C, F)$ (where SI =successful implementation, E = evidence, C =context, and F =facilitation). It is particularly relevant to this study because it will provide a conceptual map of what needs attention to ensure successful MBCT implementation, including evidence (e.g. NICE recommendations), context (what facilitates and inhibits evidence use - at micro [individual], meso [team], and macro [service] levels) and facilitation (what mechanisms/approaches/strategies have been helpful in enabling services to deliver MBCT).

Approach. This is a two-phase exploratory and explanatory research study, using an interview survey and case studies.

Phase 1 – Interview survey. This phase will scope existing provision of MBCT, ascertain views about embedding MBCT into service delivery, including models of teacher training, facilitators, barriers, costs and benefits. The findings from this phase will give us a broad and high level perspective on if, and how MBCT is being delivered across the four countries of the UK, including the factors that have facilitated and/or hindered its implementation at the level of commissioning and service delivery. We will use telephone and face-to-face interviews with a range of stakeholders across UK services.

Phase 2 – Case studies¹⁴¹. In-depth case studies using exploratory and interpretive methods will be conducted. In contrast to Phase 1, which will provide a broad and overarching perspective of MBCT service delivery in the UK, Phase 2 will provide an in-depth and contextually rich description of how MBCT becomes embedded (or not) within local service delivery. We have therefore chosen to conduct Phase 2 through mixed methods case studies. Case study is a particularly useful approach to understanding how interventions and initiatives operate within the ‘real life’ of practice and policy, and for making sense of complex individual, social and organizational phenomena where the investigator has little or no control. MBCT is a complex intervention involving individuals, teams, and organizations in multiple and dynamic ways, and case study provides an ideal approach for obtaining a rich understanding of implementation processes. For example, MBCT has a number of components that build on each other; it sits within care pathways for common mental health problems alongside other evidence-based treatments such as medication and cognitive-behavioural therapy; it relies on a range of individuals and organizations to train and supervise MBCT therapists; it targets more than one outcome (e.g., relapse prevention and quality of life) and; while MBCT is manualised, it is sometimes tailored to specific contexts / populations. The team has extensive experience in conducting case study research resulting in the development of new insights, and in the development of theory (e.g., 32, 33).

The case studies will establish the critical success factors for the routine and successful use of MBCT as recommended by NICE for people with recurring

¹⁴¹ In this study, a ‘case’ is defined as an NHS Trust, Health Board or commissioned organization where NICE recommendations would suggest there should be MBCT provision.

depression in service delivery and the impact this has on service users and carers. Additionally, we want to know what impedes the routine use of MBCT.

Synstudy

Guided by the study's conceptual framework and located within the MRC Complex Interventions Framework (2008), data will be synthesized across phase 1 and phase 2 to provide a rich, theory driven explanation about the implementation of MBCT in UK services. This will provide the basis for the development of an MBCT Implementation Plan (see Section 6 on analysis for more detail).

Sampling

This study is of relevance to commissioners, service managers, practitioners, patients/service users and carers. Therefore they will make up the stakeholder group that we will include in phase 1 and 2 data collection, data synstudy and in our engagement and dissemination strategy.

Phase 1. Interviewees will include commissioners, managers, MBCT teachers, referrers, service users and carers of service users. The UK provides an opportunity for a 'natural experiment' in that we propose to interview stakeholders from NHS regions from across the four UK countries to provide a broad perspective on MBCT implementation. Since the outline stage we have identified contacts within each of these regions based on our knowledge of MBCT implementation through the provision of training, supervision and consultancy to NHS services. Sampling ensures the inclusion of a variety of stakeholders with criteria being developed to include different roles, and involvement in the delivery of MBCT services.

The sampling framework for interviews ensures the inclusion of relevant stakeholders from each geographical NHS region. Within each area we will begin with a stakeholder who has knowledge of MBCT service delivery across their region, and will then seek out other stakeholders who are involved in the delivery of MBCT services, commission the service, use the service or refer to the service. Within the purposively sampled pool of eligible interviewees we will sample at random. Our preparatory work has involved securing permission from a key stakeholder in each region. In addition to the identified stakeholder, we propose to interview *up to* 9 additional people in each of the following NHS regions: England North, Midlands, South and London, Wales, Scotland and Northern Ireland (i.e., a sample of up to 70 people). We will stop interviews within the regions when we are confident we have a holistic picture of service delivery in that area, and in consultation with the Project Advisory Group.

Phase 2. We will sample ten cases to enable the differing UK service structures and contexts to be represented. Within cases, data will be collected to include the

perspectives of local commissioners, managers, MBCT teachers, referrers, practitioners and service users. Criteria for sampling include:

- Geographic area. We will sample sites across Northern Ireland, Scotland, Wales and England. [We are aware from our feasibility work that there are no fully embedded services in Wales.]
- Extent of MBCT being embedded in service delivery. We will include 4 sites where MBCT has been integrally embedded, and intend to spend up to 4 weeks within the site intensively collecting data. Here, we will seek to recruit cases where the organization has an explicit strategy for MBCT implementation; clinicians have been trained to teach MBCT to minimum practice levels; MBCT classes are available as evidenced by throughput of clients and predictable availability of provision and; referrers are informed and knowledgeable about MBCT service provision.

A further 4 sites will be where MBCT implementation has been partial. These sites are characterized by the absence of a compelling organizational strategy for implementation, MBCT teachers working in isolation, or the organization has an explicit strategy but is at an early stage in implementing it. Our understanding from contact with stakeholders in these sites is that the narrative may be more limited. Therefore we intend to spend up to 2 weeks in these sites collecting data.

Finally we will sample 2 sites where there is no MBCT implementation. These sites are characterized by the absence of any MBCT provision. We intend to spend up to 2 weeks in these sites collecting data.

- Across the 10 sites we will ensure we have a distribution representative of the UK population with respect to socio-demographic profile, deprivation index, prevalence of mental health problems, urban vs. rural, and ethnic profile.

Based on the above criteria, sites have been approached and their agreement in principle to participate secured (see Table below). Permission has been secured from more sites than are needed, enabling us to choose which sites to use based on outcomes in phase 1, the contextual analysis of each site and following this random selection. We have also shared our data collection plans with potential sites, to assess feasibility. They have indicated that the proposed research would be acceptable and viable. We will need to recruit an additional two case study sites where there is no implementation.

Within the sites we will use criterion sampling to identify participants and data collection opportunities. Criteria include:

- Different stakeholder views about MBCT delivery locally – including from managers, service users, practitioners, teachers, referrers and commissioners.
- Level in organization – to ensure macro, meso, micro levels (as outlined above) of the organization are included.

When we have a list of potential participants, we will randomly sample potential interviewees.

Table. Phase 2 sites

Embedded	
Oxleas NHS trust	Kim Griffiths, Clinical Psychologist,
Sussex Partnership NHS Foundation Trust	Robert Marx, Clinical Psychologist
Devon NHS Primary Care Trust	Alison Evans, AcCEPT Clinic, Exeter University
Oxford Health NHS Foundation Trust	Maria Johanson, Oxford Mindfulness Centre
NHS, Tayside	Neil Rothwell, Chair of the Scottish NHS Mindfulness Network
South London & Maudsley NHS Foundation Trust	Janet Wingrove, Clinical Psychologist
Nottinghamshire Healthcare NHS Trust	Tim Sweeney, MBCT clinical lead
Coventry & Warwickshire Partnership NHS Trust	Esther Riggs, Counselling Psychologist

Partially embedded	
NHS Greater Glasgow and Clyde	Neil Rothwell, Chair of the Scottish NHS Mindfulness Network
Berkshire NHS Foundation Trust	Pamela Duckerin, Clinical Psychologist
Surrey and Borders Partnership NHS Foundation Trust.	Lorraine Nanke, Clinical Psychologist
Central and North West London NHS Foundation Trust	Denise Ratcliffe, Clinical Psychologist
5 Boroughs Partnership NHS Trust Liverpool	Maureen Boyd, CBT senior practitioner
Southern Health NHS Foundation Trust	Ali Lambie, Primary Care Counselling

	Service Manager
Lancashire Care Trust	Lisa Graham, CBT therapist

Setting/context

This study will be conducted in the health service within England, Northern Ireland, Scotland and Wales.

Data collection

This study will use a mixed qualitative methods approach.

Phase 1 will be used to scope existing services, begin to understand perceived benefits and costs of embedding MBCT in services and begin to explore facilitators and barriers to implementation. In line with Grol's approach to quality improvement in healthcare (30), we will use established benchmarks of what a good MBCT service should comprise to inform the interview schedule (See Section 3.1). We will conduct semi-structured telephone or face-to-face interviews with stakeholders from geographically representative services across the UK (as described above). A structured interview schedule will be developed that focuses on describing extant services, perceptions about existing provision of MBCT, ascertaining views about embedding MBCT into service delivery, including models of teacher training, facilitators, barriers, costs and benefits. The interview schedule will also ensure the opportunity for interviewees to provide additional information about service delivery not guided by the schedule. Interviews will be audio-recorded. Emerging findings from Phase 1 will be used to inform choice of case studies and develop data collection tools for Phase 2.

Phase 2 is concerned with gaining an in-depth understanding of MBCT implementation in local service delivery. Therefore data will be collected to ensure description and the potential for explanation, and enable the articulation of critical success factors for the routine and successful implementation of a high quality MBCT service that helps people with recurrent depression stay well in the long-term (1, 10).

Within each site a number of data collection methods will be used concurrently:

Semi-structured interviews. In each site, up to 20 interviews will be conducted either face to face or by telephone (at the interviewees' convenience), and will be audio-recorded. Based on our previous case study research (32,33), we anticipate that a maximum of 20 interviews will provide both the depth and breadth of information about an issue. This number is also practical within the timeframe of the project and not too burdensome on sites.

A semi-structured interview schedule will be developed to explore how MBCT services were developed, how they are delivered, how they were/are being implemented (e.g. strategies and approaches), who was/is engaged in implementation, and how services are being evaluated. The schedule will also be informed by emerging findings from Phase 1, so that issues that emerged at this stage can be explored in more depth. Additionally, we want to know what impedes the routine use of MBCT because this will be valuable information in the development of an MBCT Implementation Plan. This will include exploring where barriers to access exist even where there are MBCT services. For example, our service user reviewers of the outline proposal highlighted difficulties in obtaining a referral as key, in several cases even where there was a service. Finally, we want to understand what audit and evaluation procedures are routinely used by primary care and MBCT services to monitor referrals, costs and outcomes.

Non-participant observation of relevant naturally occurring meetings and events within each site will be undertaken, such as MBCT implementation steering group, depression pathway steering group, commissioner monitoring meetings, clinical special interest/supervision groups or relevant service user meetings. Observations will provide a supplementary source of data to the interviews by providing a view on context related issues, including how organizations and services are responding to the challenge of implementing MBCT. As these are naturally occurring meetings and events, we cannot anticipate how many observations will be conducted.

We will use Spradley's 9 dimensions (1980) of observation to guide the focus of data collection, which include Space, Actors, Activities, Objects, Acts, Time, Events, Goals and Feelings (34). These dimensions have been used successfully in other projects to record useful information about processes, content and interactions. Observations will be written up as field notes.

Documentary analysis relevant to (a) implementation (e.g. plans, pathways, guidance), and (b) context of implementation (e.g. about wider initiatives, success stories, critical events/incidents, outputs, changes in organization) will be collected and analyzed. These will provide information with which to further contextualize findings, provide insight into influences of implementation, and help explanation building.

Context analysis will include using national databases and census data to establish the socioeconomic distribution, ethnic profile and rates of mental health problems of the population that the case study services serve. This will enable us to provide a profile of the (macro) context for each case study and ensure we have a representative set of

case studies with respect to these variables. This profiling will be completed before the set of cases to be studied is finalised.

Synstudy and development of MBCT Implementation Plan

The data collected across phases 1 and 2 will be synthesized to develop an Implementation Plan. The design and content of the MBCT Implementation Plan will be developed in consultation with the Project Advisory and Patient and Public Involvement Groups and in the light of the Phase 1 and Phase 2 findings. In addition to the evidence gathered in Phase 1 and 2, the synstudy will also be informed by high quality implementation science reviews and evidence syntheses (30, 35, 36). Where there are established factors known to enhance implementation these will be incorporated into the synstudy and Implementation Plan (e.g., addressing structural barriers, engaging opinion leaders, awareness building, activities that engage patients/patient groups). Whilst we will not pre-empt the exact detail of its content, we envisage the Implementation Plan will comprise at minimum a toolkit including strategies for successful implementation, implementation approaches, training manuals and measurement/evaluation tools. Engagement with the stakeholder groups will ensure the MBCT Implementation Plan is relevant, accessible and of high utility to service providers to both facilitate more successful implementation of MBCT into service delivery, and be able to measure the impact of implementation. We have built into the project timeline and project resourcing active engagement of the stakeholder groups to ensure the success of this phase of work.

Data analysis

Qualitative data from interviews, observations and documents will be analyzed using a thematic analysis approach informed by Ritchie and Spencer (13), and Yin (14). A process of inductive and deductive analysis will be undertaken informed by Ritchie and Spencer's approach to analysis (1994), specifically, their approach to concept identification and thematic framework development. We will use the data from the interviews as the main source of information, and look for refutational or complementary findings from observations and documents. Qualitative audio-recorded data will be transcribed in full, and managed in NVIVO.

First, data will be analyzed within data set (interviews, observations, documents). A number of transcripts will be coded inductively, and these codes used to develop an analysis framework. The framework will be used to code the remaining data and refined as new codes emerge. Second, the findings that emerged within the data set will be reviewed and mapped against the key elements of the study's conceptual framework. This will result in the development of higher-level themes.

Consistent with comparative case study, each case will be regarded as a 'whole study' in which convergent evidence is sought and then considered across multiple cases (14). As such, a pattern matching logic, based on explanation-building will be used. This strategy will allow for an iterative process of analysis across sites and will enable an explanation about MBCT implementation to emerge - what works, and what has not worked, and importantly, why. It will be imperative to ensure that data analysis reflects the variety of data sources and the potential insight that each could offer in meeting the study objectives. Analysis will first be conducted within sites and then to enable conclusions to be drawn for the study as a whole, findings will be summarized across sites.

The study's PARIHS conceptual framework will facilitate data integration in that it will provide a heuristic for managing the themes from the various sources of information. Use of the framework will also provide potential opportunities for theory evaluation and development. Several members of the research team will carry out the analysis process, which will include cross checking, coding and theming. Emerging themes will also be shared periodically with the whole research team, including service users, as an additional check on credibility. At various stages the stakeholder groups will input on the emergent analysis.

Dissemination and projected outputs

Knowledge transfer and exchange into improving service delivery in the NHS is integral to our proposal and will be facilitated throughout the project. Stakeholder involvement, including robust engagement with patients and the public will provide opportunities for exchange and transfer. We will also engage the mental health charities with whom we have established links in disseminating the study outputs (e.g., Depression Alliance).

Plans for dissemination

This study will provide the evidence base for how to increase the implementation and accessibility of MBCT into services across the UK. Therefore ultimately there is the potential for services to be delivered more in line with NICE recommendations and in ways that maximize equitable access to evidence-based therapies across the UK. We will achieve this through the following dissemination activities.

- Website presence of the project through linkages on appropriate sites. The Bangor University's Centre for Mindfulness Research and Practice, Exeter Mindfulness Network and Oxford Mindfulness Centre websites between them have considerable reach into key stakeholders in this research.
- Publication of the project protocol in an open access journal.

- Publication of the key output in an open access journal that sets out the MBCT Implementation Plan building on best practice in a variety of contexts.
- A resource pack/toolkit/report that includes an executive summary and bite sized sections that allow for rapid scanning that can be used by GPs, service managers and clinicians, and is available to service users so they know what services they are entitled to.
- In line with NIHR Carbon Reduction Guidelines we will make the resource pack/toolkit/report materials freely available online.
- Summaries of findings written appropriately for different audiences.
- Newsletters. Bangor University's Centre for Mindfulness Research and Practice, the Oxford Mindfulness Centre and Exeter Mindfulness Network websites each produce regular newsletters that are disseminated >5000 people. In addition, by working collaboratively with all the study stakeholders we can disseminate the findings across all the UK NHS regions.
- Conference presentation at the UK national conference for mindfulness-based applications and for health services research (e.g. NHS Confederation Annual Conference).
- Workshops delivered across the UK for service managers, user groups and MBCT teachers to support the implementation plan that involve interactive educational meetings that enable delegates to adapt the materials to their local context. We envisage offering a workshop in each of the 4 NHS regions in England, and in Wales, Scotland and Northern Ireland. These workshops will build on workshops that three of the applicants are planning in collaboration with key stakeholders involved in implementation in the health service. See http://www.bangor.ac.uk/mindfulness/documents/implementationPostConferenceInstituteDetails_001.pdf
- Our intention is to use the outputs of this study to set up an adequately powered pragmatic implementation trial in the final phase of the MRC Complex Interventions Framework. This would evaluate the MBCT Implementation Plan's effectiveness in real world populations, addressing outcomes that are recognized in the NHS, against a comparator group that allows a good test of effectiveness. The proposed research will inform the choice of setting / population, intervention parameters, outcomes and control group, as well as the study design (e.g., cluster randomized controlled trial, balanced block design).
- The study will also provide transferable evidence about implementation of NICE recommended services. There is still much to learn about implementation within and

across contexts and different types of services/clinical issues. This study will therefore extend our knowledge about implementation theory and practice.

- Finally, this study will also provide the groundwork to extend the programme to MBCT for long-term conditions, for example for people with vascular disease. A project supported by the NIHR Peninsula CLAHRC adapting MBCT for people with co-morbid depression and long-term conditions is at the feasibility stage of the MRC complex interventions framework. We envisage in time extending this through the MRC Complex Interventions Framework phases to include implementation (<http://clahrc-peninsula.nihr.ac.uk/project/46-mindfulness-based-cbt-for-depression-with-chronic-physical-health-problems.php>).

15. Table 5 showing post-MBI support being offered across Sussex and other follow-up support mechanisms identified as important in the data

Postcode	Lat/Long	Name of MBI provider	Follow-up support
BN2 4DE	50.839498, - 0.112384	Sussex Beacon. HIV service. http://www.sussexbeacon.org.uk/mindful.html	Once course is completed participants are invited to attend monthly 2 hour mindfulness group and every 6 – 8 weeks a whole day of mindfulness (this is also at no cost to the participants and is funded via charity monies). Numbers wishing to attend follow up group is 25 – average number of attendees at each monthly and day of mindfulness = 8
BN1 1UR	50.825003, - 0.139937	Brighton Buddhist Centre: http://www.brightonbuddhistcentre.co.uk/health.html#eastbourne	Offers a monthly drop in class at the Buddhist centre for anyone who has completed an MBCT course and have also offered 'level 2' course. A monthly drop-in class for people who have completed a Mindfulness Based Cognitive Therapy for Depression and Stress course (either at the Brighton Buddhist Centre or at Evolution). Cost: £5 (£3 conc.)
BN1 3XG	50.825803, - 0.142285	MINDOUT (lesbian, gay, bisexual and transgender charity)	Free Refreshers for anyone who has previously been on an MBCT course (only been 2 run). This is the first refresher MindOut has run. A follow up session in 4 weeks, and day of practice (usually one per year). Take up varies, can be very low, but the last one was about 80%.
BN2 0JL	50.821725, - 0.129902	Mindfulness Brighton: Anahata Health Clinic, 119/120 Edward Street	Have offered a few follow-ups but take up was not great; put this down to the huge amount of meditation and yoga groups in Brighton. Do 'refresher sessions' and a few

			people keep coming back to these. These provide an opportunity to reconnect with the practices and spirit of the MBCT course. The intention is for this to be a resource to help people support, and if necessary re-invigorate their practice.
RH17 5JZ	51.005488, - 0.143062	Mindfulness Sussex: http://mindfulnesssussex.co.uk/	Have a 'Graduates' webpage and program: http://mindfulnesssussex.co.uk/graduates.html . Graduate Practice Retreats Graduate retreats offer a chance to reconnect with the practices and to take them deeper. 12.30 - 6.00pm. 4xyear graduate mornings and 2x year grad retreat days. 1x year graduate residential weekend.
BN3 5QJ	50.833478, - 0.185893	Dheeresh Turnbull- http://www.learningtoplayyourmind.com/ ,	The drop-in group was set up as a follow up for people who had done the eight week course (either with me or anywhere), but it began to attract people who had not done it and did not want to turn anyone away. Over several years it has morphed into a (primarily) Zen group, but still mention it to people who have done a course as one way of keeping up practice. Called 'The Hove Zen & Mindfulness Sangha' which gives an idea of the range.
PO21 2RJ	50.781716, - 0.684286	http://www.clairecolecounselling.co.uk/Mindfulness.htm	Runs drop-ins and day retreats for graduates of other 8-week courses. Run a monthly drop in for any participant of

			any 8 week course, and also the occasional stand-alone retreat day.
BN11 4NN	50.817825, - 0.386671	Circle of Support Counselling and Therapy http://www.circleofsupport.co.uk/mindfulnessworkshops.html	Intend to hold morning refreshers regularly. £10 per session
TN6 1XP	51.063702, - 0.142785	Julie Stannard. http://www.clearmindinstitute.co/members/julie-stannard/	Have offered two follow up sessions previously and there was reasonable take-up.
BN1 4GB	50.827636, - 0.135712	Brighton Therapy Centre: http://www.brightontherapycentre.org.uk/therapies/mindfulness-based-therapy/ .	1 day. Take up is varied, and is lower than the course itself, averaging on around 5 or 6 people
PO20 0JE	50.727630, - 0.786502	Mindfulness Meditation Zone, ('Mindful 'i' program): http://www.mindfulnessmeditationzone.com/mindfulness-meditation-chichester/ . Mindful Living and Practical Meditation for Adults, Kids and Stressed-Out Executives http://www.mindfulnessmeditationzone.com/	Follow up is generally based on some level of coaching or additional sessions (and some include course notes). Just launched a DVD now available on Amazon and have an online Mindfulness course people can benefit from at home.

Other suggestions for follow-up support suggested in the data:

- Motivational reminders to practice

- Peer support and buddying systems
- Central support in physical groups or getting groups online at a particular time, as well as '*Bibliotherapy*' in the form of a book when they leave, which could be used in an active sense as part of an action planning approach based on a '*In situation X I will do Y*' format.
- NICE Guidelines for Peer Support for Mental Sickness (CG123) physical spaces and online forums could be better utilised.
- Importance of a tailored approach with flexibility as key as well as motivation and knowledge about own capacities.